NEBRASKA COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT
"Nebraska State Plan Implementation Report for FY2004"

Nebraska Department of Health and Human Services
Office of Mental Health, Substance Abuse and Addiction Services

PART D – IMPLEMENTATION REPORT

PART E – UNIFORM DATA ON PUBLIC MENTAL HEALTH SYSTEM

The Nebraska State Plan Implementation Report is prepared to address the requirements under Section 1942(a) of the PHS Act (42 U.S.C. 300x-52). This report is due to the U.S. Department of Health & Human Services / Center for Mental Health Services (CMHS) by December 1, 2004. The State Advisory Committee on Mental Health Services (State Mental Health Planning Council) reviewed the report on November 10, 2004. Send questions or comments on this report to:

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PART D: IMPLEMENTATION REPORT

SECTION ONE: FY2004 PURPOSES BLOCK GRANT EXPENDED, BY SERVICE TYPE AND RECIPIENTS OF FUNDS

Use of Federal Mental Health Block Grant in FY2004

This is a report on the purposes for which the block grant monies for State FY2004 were expended, the recipients of grant funds, and a description of activities funded by the grant.

- **Purpose** – the funds were used in two ways. (1) the primary purpose was to purchase community mental health services. (2) the 5% administrative portion was used to support Adult Goal #3: Empower Consumers.

- **Recipients of Grant Funds** - the six Regional Behavioral Health Authorities were the recipients of the funds. A small amount is used to fund Rural Service Equity. Rural Service Equity are funds allocated as needed to rural areas.

  The "Nebraska Behavioral Health Services Act" (LB1083) sections 7-9 revised the regional administration of the system. LB1083 retained the six geographic "regions" established in 1974. LB1083 re-authorized the six regions and renamed them "Regional Behavioral Health Authorities" (RBHA). The RBHA are local units of government organized under the Interlocal Cooperation Act for the purpose of planning, organizing, staffing, directing, coordinating and reporting of the local service systems of mental health, and substance abuse within assigned geographic areas (regions). There are six Regional Behavioral Health Authorities in Nebraska. Each county participating in the region appoints one county commissioner to the Regional Governing Board to represent that county and to participate in the decision making of the Regional Behavioral Health Authority (RBHA). The RBHA is staffed by the Regional Program administrator who in turn hires sufficient staff to accomplish the tasks within the region. RBHA contracts with local providers for service delivery.

- **Expended / Description of Activities** - the table below shows how the funds were expended with a brief description of services funded by the grant.

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Totals	% of Total
ADULT SERVICES								
NON-RESIDENTIAL SERVICES								
L 1 – Day Treatment - MH					$20,000		$20,000	1.1%
L 4 – OutpatientTherapy - MH (Ind/Grp/Fam)	$29,419		$43,134	$35,066	$144,000	$ 173,708	$425,327	22.8%
L 4 – OutpatientTherapy - Dual (Ind/Grp/Fam)			$8,928				$8,928	0.5%
L 5 – Medication Management – MH	$6,032	$40,504	$50,910			$ 45,000	$142,446	7.6%
L 5 – Day Support - MH	$33,360		$41,600				$74,960	4.0%
L 5 – Vocational Support - MH	$1,440		$15,534	$38,798			$55,772	3.0%

Day Rehabilitation		$100,602				$ 22,176	$122,778	6.6%
Dual Residential (SPMI/CD)					$15,000		$15,000	0.8%
Psych Residential Rehab						$ 62,576	$62,576	3.4%
Community Support - MH		$31,689	$15,240	$33,095		$ 8,825	$88,849	4.8%
Capacity Access Guarantee / Community Support				$1,721			$1,721	0.1%
Adult Totals	$70,251	$172,795	$175,346	$108,680	$179,000	$312,285	$1,018,357	54.6%
% of Total Federal on Adult Services	37.7%	92.0%	65.4%	39.9%	40.8%	61.0%	54.6%	
CHILDREN/YOUTH SERVICES								
Professional Partner - School WRAP	$78,000			$83,850			$161,850	8.7%
Professional Partner			$50,000	$80,000	$150,921	$ 200,000	$480,921	25.8%
C/Y Day Treatment	$38,000		$42,856				$80,856	4.3%
C/Y Intensive Outpatient - MH					$35,838		$35,838	1.9%
C/Y MH Therapeutic Consult					$73,000		$73,000	3.9%
Federal Children's Set Aside / P.L.100-690		$15,000					$15,000	0.8%
Youth Totals	$116,000	$15,000	$92,856	$163,850	$259,759	$200,000	$847,465	45.4%
% of Total Federal on Youth Services	62.3%	8.0%	34.6%	60.1%	59.2%	39.0%	45.4%	
GRAND TOTAL MH $ - Report of Actual	$186,251	$187,795	$268,202	$272,530	$438,759	$512,285	$1,865,822	100.0%

GRAND TOTAL MH $ - Report of Plan (Aug 03)	$186,251	$187,795	$268,202	$272,545	$438,759	$583,228	$1,936,780
Plan – Actual (unexpended balance)	$0	$0	$0	$15	$0	$70,943	$70,958
Rural Service Equity (3%)							$63,904
State Administration (5%)							$105,299
FY2004 TOTAL FUNDS							$2,105,983

Source: Nebraska Department of Health and Human Services
Office of Mental Health, Substance Abuse and Addiction Services
As reported by the Regional Behavioral Health Authorities / September 2004

DESCRIPTION OF ACTIVITIES / ADULT SERVICES

- Day Treatment – Specialized medically based day program for persons with serious mental illness that enables a person to live independently and still attends an intensive program including assessment, individual, family and group therapy, and medication services as developed by a multidisciplinary team. Programming usually involves 6-8 hours of activity per day/6-7 days per week. Length of service varies depending on individual needs but is usually not longer than 21-45 days.

- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for a variety of mental health problems which disrupt individual's life that includes counseling and talk therapy treatment to change behavior, modify thought patterns, cope with problems, improve functioning; may include coordination to other services to achieve successful outcomes. Length of service varies depends on individual illness and response to treatment but averages 10 sessions at least once per week. Group therapy sessions include approximately 3-8 persons. Family counseling are included in this service level.
- Medication Management – Prescription of appropriate psychotropic medication (usually, but not limited to persons with severe and persistent mental illness), and follow-up to therapeutic response, including identification of side effects. Medication checks usually take 15-30 minutes with the psychiatrist, an/or a nurse or case manager.
- Day Support (Drop-In Center w/Peer Support) -- Facility based program for persons with severe and persistent mental illness. This transition "drop-in" center for persons who have not yet enrolled in Day Rehabilitation, or who have completed their rehab plan in the Day Rehab service and want to continue to socialize with friends they have made at the Day Rehab service is designed to engage consumers. This service does not require a service plan but provides an environment to be with other people who share the same life and illness situation. Persons with severe and persistent mental illness are hired as peer specialist staff in this program. Additional support including outreach are the main focus of this drop in center. Pre-Day Rehab consumer length of stay may be 3-6 months. Post-Day Rehab consumer length of service is very individualized and may range from 6 months – 5+ years.
- Vocational Support – Ongoing support for persons with severe and persistent mental illness after they have secured long term employment. The support activities general take place off the job site, but can include assistance in learning job duties, problem solving and other job functions in order for individual to maintain gainful employment. Length of service depends on individual consumer need but is usually not longer than 6-24 months.
- Day Rehabilitation – Facility based day program for a person with severe and persistent mental illness that focuses on psychosocial rehabilitation after treatment has stabilized the mental illness. Provides prevocational and transitional employment services, planned socialization, skill training in activities of daily living, medication management, and recreation activities are focused on returning a person to work and maintaining independence in the community. Programming usually involves 5 hours of activity per day/5 days per week and some weekends. Length of service varies depending on individual needs but is usually not longer than 6 months – 5 years.
- Dual Residential -- Facility based program that provides simultaneous integrated treatment for individuals with severe and persistent mental illness and chemical dependence. Includes medication management and psychosocial rehab as well as treatment for stabilization and recovery. Substance abuse and mental health professionals staff the service. Substance abuse and mental health treatment are integrated. Length of service varies depending on individual needs but is not longer than 4-8 months.
- Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.
- Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the

residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES

- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Access to services on a 24-hour, 7day/week basis. Uses a wraparound approach to coordinate services and supports to families. Includes coordinated assessment, flexible funding to provide support, based on needs as outlined by a multidisciplinary team. Emphasizes family empowerment and involvement in planning.
- School Wraparound – In this variation of the Professional Partner Program, a special education teacher, team teacher, or school social worker works with the Professional Partner and the Child and Family Team to coordinate the school plan. Based on the LaGrange Area Department of Special Education (LADSE) approach in LaGrange, Illinois, a team of two wraparound service coordinators are based in the school. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This School-Based Wraparound Approach allows the teacher and/or other school personnel to feel comfortable voicing classroom based concerns (academic and behavioral) and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.
- Day Treatment – Facility based program serving children and adolescents with Severe Emotional Disturbance. Intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for mental health problems which disrupt a youth's home, school, family functioning; treatment focuses on changing behavior, modifying thought patterns, coping with problems, improving functioning and may include coordination to other services to achieve successful outcomes. Length of service varies depending on individual needs but is usually not longer than 10 sessions no more than once per week.
- Therapeutic Consultation – Collaborative, clinical intervention for youth with early indications of Severe Emotional Disturbance. Multidisciplinary based interventions with family, teachers and mental health professional involvement in the school or other natural setting.

PART D: IMPLEMENTATION REPORT
SECTION TWO:
SUMMARY OF SIGNIFICANT EVENTS

SIGNIFICANT ACHIEVEMENTS IN ITS PREVIOUS FISCAL YEAR

This section will be discussing the Governor's Behavioral Health Reform Initiative and the passage the Nebraska Behavioral Health Services Act (LB 1083). The Governor's Behavioral Health Reform Initiative covers a number of areas including significant achievements during the last year that reflect progress towards the development of a comprehensive community-based mental health

system of care, new developments and issues that affect mental health service delivery in the State, as well as legislative initiatives and changes.

Governor's Behavioral Health Reform Initiative

For the last several years, Governor Mike Johanns has publicly stated that behavioral health reform was his priority.

- LB 724 (2003): Established a "roadmap" for reform of the public behavioral health system and outlined focus areas for reform. Both State Senator Jim Jensen and Governor Johanns were involved in "Nebraska Behavioral Health Reform Act" (Legislative Bill 724-2003). This bill was approved by the Governor on May 13, 2003. The purpose of LB724 was to indicate legislative intent for reform of the behavioral health system and for a substantive recodification of statutes relating to the funding and delivery of behavioral health services in the State of Nebraska.
- LB 710 (2003): Proposed recodification of the Nebraska Mental Health Commitment Act.
- In the Lincoln Journal Star (June 9, 2003), Governor Mike Johanns said, if he was forced to pick just one area he could influence during his remaining days as Governor, it would be **mental health**.
- In that same article Omaha State Senator Jim Jensen, Chair of the Health and Human Services Committee of the Nebraska Legislature, said he is looking for ways to provide more housing and treatment services in local communities and examine the need for three regional centers.
- LB 1083 (2004): Implemented the reform intent in the focus areas of state leadership, regional administration, statewide advocacy, funding, and legislative oversight. It requires planning for the statewide development of community-based behavioral health services and reduction in the necessity and demand for regional center services.

In his "State of the State Address" on January 15, 2004, Governor Johanns said one of his five goals for the legislative session was mental health reform. Two of the seven pages of the Governor's address were devoted to the mental health reform. The Governor said, "First, I implore you to reform our mental health system. Senator Jensen and I have worked on mental health reform virtually every day since the last day of the last session. He has courageously put forth LB 1083 to achieve this reform." The Governor went on to say, "We have a compelling moral responsibility to see that these individuals are cared for in the least restrictive environment". The Governor also said, "The legislation before you is the right thing to do. It commits us to a course of recovery for these citizens in their communities, near their support systems". For the complete text of the Governor's address, see http://gov.nol.org/johanns03/speeches/sos2004/index.html.

On April 14, 2004, Governor Mike Johanns signed into law Legislative Bill 1083, the Nebraska Behavioral Health Systems Act (LB1083). The final vote in the Nebraska Legislature was 44 in favor, 2 against, 3 not voting. Introduced by State Senator Jim Jensen, this historic legislation reforms Nebraska's behavioral health services by moving from an over-reliance on state-owned Regional Centers to creation or expansion of acute inpatient, secure residential and support services in the community. LB 1083 intends to provide services closer to home and in the least restrictive, appropriate setting while accessing federal Medicaid dollars. LB1083 addresses issues relating to behavioral health services, mental health commitments, affordable housing, and alcohol and drug abuse counselors. LB 1083 represents implementing legislation required by LB 724 (2003). LB1083 will eventually close the regional centers in Hastings and Norfolk to create more community-based programs for treating behavioral health disorders. More information on LB 1083 can be accessed at the HHSS website at http://www.hhs.state.ne.us/beh/reform/.

Mechanism to Close a Regional Center

LB1083 creates the Division of Behavioral Health Services, within the Nebraska Department of Health and Human Services. LB1083 Section 10 provides key directions for the changing of the Behavioral Health System in Nebraska

- Section 10 (1) instructs the Division to encourage and facilitate the Statewide development and provision of an appropriate array of Community-Based Behavioral Health Services and continuum of care.
- Section 10 (2) says the Division may reduce or discontinue Regional Center Behavioral Health services only if appropriate community-based services or other Regional Center Behavioral Health services are available for every person receiving the Regional Center services that would be reduced or discontinued.
- Section 10 (6) says the division is to notify the Legislature and Governor when occupancy of the licensed psychiatric hospital beds of any Regional Center reaches 20% or less of its licensed psychiatric hospital bed capacity on March 15, 2004. The Legislature's Executive Board may grant the division permission to close the center and transfer any remaining patients to appropriate community-based services.
- Section (7) states that the provisions of Section 10 are self-executing and require no further authorization or other enabling legislation.

Core Principles of Behavioral Health Reform

- Consumers will have services that better meet their needs and are closer to their families and communities
- Community services must be in place before patients are transitioned
- Acute and Secure hospital levels of care will continue to be required
- Current funding will be leveraged with Medicaid match dollars and re-invested in the appropriate community services
- Reform will happen in incremental steps

Key events and timelines in LB 1083 include:

(1) On June 16, 2004, State Senator Jim Jensen announced appointments to the Behavioral Health Oversight Commission of the Legislature. The commission was mandated in LB 1083 Section 18. The members of the Behavioral Health Oversight Commission (commission) were appointed by State Senator Jensen and confirmed by members of the Health and Human Services Committee (committee). The first meeting of the commission was held on Friday, July 9, 2004. Commission meetings are open to the public. Future commission meetings will be on the second Friday of each month through December 2004. Future meeting dates are as follows: August 13, September 10, October 8, November 12, and December 10. Meeting locations will be announced. The committee has directed the commission to take all necessary and appropriate steps as permitted by law to ensure that input is received from consumers of behavioral health services and from all areas of the state, including those areas that are underserved and not currently represented on the commission.

(2) On July 1, 2004 the Nebraska Health and Human Services System (HHSS) submitted a Behavioral Health Implementation Plan (BHIP) as required by LB1083 sections 19-20. A complete PDF version of the 208-page document and other information regarding implementation of LB 1083 can be accessed at the HHSS website at http://www.hhs.state.ne.us/beh/reform/.

(3) The Commission is to review and make recommendations relating to the BHIP on or before October 1, 2004.
(4) HHSS is to respond to the Commission recommendations on or before December 1, 2004; and
(5) Follow-up legislation may be introduced in the Nebraska Legislature in January 2005.
(6) LB 1083 Section 5(2) created a new position of Behavioral Health Administrator. On September 17, 2004, Governor Johanns announced the appointment of Richard DeLiberty of Carmel, Indiana to the position of Behavioral Health Administrator for the Nebraska Department of Health and Human Services. He started in this new position on October 18, 2004.
(7) The Nebraska Behavioral Health Services Act created the State Behavioral Health Council, State Advisory Committee on Mental Health Services, State Advisory Committee on Substance Abuse Services, and the State Advisory Committee on Problem Gambling and Addiction Services (Neb. Rev. Stat. §§71-813 to 71-816). On November 9 and 10, 2004, the first meetings of the three committees occurred. Governor Johanns, State Senator Jensen and Richard DeLiberty addressed the group on November 9, 2004. Governor Johanns noted that his second term ends in two years. Before he steps down, Governor Johanns said he hopes to see a broad array of community-based services across the state to help prevent people with mental illness from reaching the crisis point and help them lead normal lives.

PART D: IMPLEMENTATION REPORT
SECTION TWO:
REVIEW OF CRITICAL GAPS / UNMET NEEDS

AREAS WHICH THE STATE IDENTIFIED IN THE PRIOR FISCAL YEAR'S APPROVED PLAN AS NEEDING IMPROVEMENT;

GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
CHILDREN
UPDATE – November 2004

Below is the unduplicated count of persons served, all programs (community mental health, community dual programs, and Regional Center services) as reported on the Uniform Reporting System 2004 Report

- Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

	Table 2A	Table 14A
	Total	SED / SMI Total #
0-3 Years	179	84
4-12 years	595	37
13-17 years	1,002	152
Total age 0-17	1,776	273
18-20 years	1,062	231

21-64 years	15,014	6,336
65-74 years	342	176
75+ years	195	71
Not Available	7	2
Total age 18+	16,620	6,816
Total	18,396	7,362

PENETRATION RATE / CHILD SED

- Number of Nebraska Youth Resident Population Age 9 to 17 = 227,347
- Resident Population who are children with Serious Emotional Disturbances (SED)
  22,735 = SED estimated in 2003

source: Ronald W. Manderscheid, Ph.D. 8/13/2004
Chief, Survey and Analysis Branch
Center for Mental Health Services (CMHS)
Substance Abuse & Mental Health Services Administration (SAMHSA)
U.S. Department of Health & Human Services

Summary – Penetration Rates / 2004 for Youth

22,735	SED estimated by CMHS *
1,776	Child / URS Table 2A NE FY2004 Implementation Report
8%	Penetration rate based on Table 2A
273	Child SED / URS Table 14A NE FY2004 Implementation Report
1%	Penetration rate based on Table 14A

NOTE 1: Uniform Reporting System (URS) Table 14A for FY2003 requested counts for Persons Served with SED using the definitions provided by the CMHS.

NOTE 2: These data do not include the services provided by the HHS Protection and Safety nor Medicaid.

According to the Federal Center for Mental Health Services, there are 22,735 youth in Nebraska who have a serious emotional disturbance. According to Table 2A, the unduplicated count of youth served by programs funded by the HHS Division of Behavioral Health Services in the community based system and the Regional Centers were 1,776. According to Table 14A, the unduplicated count of youth served with SED by programs funded by the HHS Division of Behavioral Health Services in the community based system and the Regional Centers were 273.

Nebraska has been granted a state infrastructure grant to support systems of care at the state level. According to the grant proposal, although some Nebraska communities have developed comprehensive, integrated systems of care that provide exceptional services for children and families, these efforts are islands of excellence in a troubled sea. The State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. Vast areas of the state are frontier and rural and have severe shortages of mental health and substance abuse professionals. Of Nebraska's 93 counties, 86 are designated psychiatric shortage areas. Even when services are available, families have difficulty affording behavioral healthcare; Nebraska has seven of the 12 poorest counties in the nation. According to an Omaha World Herald

expose' on children's mental health, one in four families of children with serious mental health problems were encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford; Nebraska has the highest number of children per capita in the country who are wards of the state. Nebraska has a growing population of ethnic/racial minorities; these populations present unique behavioral health needs that the current system is ill prepared to meet. Other challenges include fragmentation across systems, lack of evidence-based services, and funding structures that are not supportive of individualized, family-centered care.

Specifically the State Infrastructure Grant application proposes to help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families.

A wide array of stakeholders are committed to this project including the state agencies responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. Local systems of care have also committed to the success of this project including the two SAMHSA system of care grantees (Nebraska Families Central and Families First and Foremost), the two Safe Schools, Healthy Students grantees in Omaha and Beatrice, and the Governor's early childhood mental health system of care initiative in central Nebraska. Other stakeholders committed to the project include two family organizations (NAMI-Nebraska and the Nebraska Federation of Families for Children's Mental Health), three state commissions (Nebraska Commission on Indian Affairs, Mexican American Commission, and the Crime Commission), other system of care communities such as Panhandle Partnership for Health and Human Services, provider organizations, faith organizations, University of Nebraska (Public Policy Center, Center for At-Risk Children's Services, Monroe-Meyer Institute) private foundations, and the Nebraska Legislature's Health and Human Services Committee.

The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

GAP #1: THE DISCREPANCY BETWEEN PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

ADULTS:

UPDATE – November 2004

URS Table 1 for the State of Nebraska: Number of Persons with Serious Mental Illness, age18 and older, by State, 2003

- Nebraska Resident Population Age 18+ Population 2003 = 1,298,451

- Adults with Serious Mental Illness (SMI) are 5.4% of the Resident Population Age 18+ Population. For 2003 that equals 70,116. *

  * Source: Ron Manderscheid (08/13/2004)
  U.S. Department of Health & Human Services
  Substance Abuse & Mental Health Services Administration (SAMHSA)
  Center for Mental Health Services (CMHS)

Summary – Penetration Rates / 2004 for Adults

70,116	SMI estimated by CMHS *
16,620	Adult / URS Table 2A NE FY2004 Implementation Report
24%	Penetration rate based on Table 2A
6,816	Adult SMI / URS Table 14A NE FY2004 Implementation Report
10%	Penetration rate based on Table 14A

According to the Federal Center for Mental Health Services, there are 70,116 adults in Nebraska who have a serious mental illness. According to Table 2A, the unduplicated count of adults served by programs funded by the HHS Division of Behavioral Health Services in the community based system and the Regional Centers were 16,620. According to Table 14A, the unduplicated count of youth served with SED by programs funded by the HHS Division of Behavioral Health Services in the community based system and the Regional Centers were 6,816.

In FY2004, the Governor's Behavioral Health Reform Initiative was passed by the Legislature. This is a major reform of the Behavioral Health System in Nebraska including community mental health (See Section Two: Summary of Significant Events above). It is expected that this reform will result in improved service capacity within the community mental health system. That should help address the discrepancy between prevalence of mental illness and the number of individuals served by the system.

GAP #2: DEVELOPMENTALLY APPROPRIATE SERVICES FOR YOUTH IN TRANSITION

UPDATE – November 2004

Focus on Prevocational/Employment:services for children with serious emotional disturbances continue to be provided through the public school system under the provision requiring transition services. The term transition services means a coordinated set of activities for a student with a disability that is designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment),continuing and adult education, adult services, independent living, or community participation; is based upon the individual student's needs, taking into account the student's preferences and interests; and includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, when appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services for students with disabilities may be special education, if provided as specially designed instruction, or related services, if required to assist a student with a disability to benefit from special education.

The Workforce Investment Act is the first major reform of America's Job Training System in fifteen years. It was signed into law by President Clinton on August 7th, 1998.
Key Components include:

- Streamlining Services - Programs and providers will co-locate, coordinate and integrate activities and information, creating a coherent and accessible one-Stop system for individuals and businesses.
- Empowering Individuals - Individual Training Accounts (ITA's) at qualified institutions will supplement financial aid from other sources and may pay for all the costs of training. A system of consumer reports will provide key information on the performance outcomes of training and education providers.
- Through ITA's, participants choose training based on program outcomes. To survive in the market, training providers must make accountability for performance a top priority.
- State and Local Flexibility - Significant authority is reserved for the Governor and chief local elected officials to implement an innovative and comprehensive workforce investment systems tailored to local and regional labor market needs.
- Improved Youth Programs
  Programs will be linked more closely to local labor market needs and community youth programs, with strong connections to academic and occupational learning.

"One-Stop" Centers serve as the cornerstone of the new Workforce Investment System. These Centers unify training, education and employment programs into one customer-friendly system in each community. At least one full-service center is located in each workforce investment area. Strategic Goals for Improved Youth Programs include:

- Nebraska parents, educators, businesses, and service providers work as partners in providing youth with opportunities for a lifelong learning environment to reflect the changing needs and skills of the workforce.
- School-to-Career efforts are strengthened and expanded in order to continually invest in our youth's future by coordinating partnerships between business, students, education, and communities.

Local areas take advantage of the School-to-Work network and existing partnerships in their areas. Collaborative planning with the schools and School-to-Work partnerships should include: preparation of all youth for adulthood, successful careers and lifelong learning, in addition to strengthening basic skills. School-to-Work partnerships can assist local Workforce Investment boards and youth councils in providing continuity between Workforce Development and the education system.

One-Stop Services to Youth
The chief elected official, as the local grant recipient for the youth program, is a required One-Stop partner and is subject to the requirements that apply to such partners.

In addition, connections between the youth program and the One-Stop system include those that facilitate:

1. The coordination and provision of youth activities;
2. Linkages to the job market and employers;
3. Access for eligible youth to the local youth program information and services; and (4) Other activities designed to achieve the purposes of the youth program and youth activities.

Local boards have the flexibility to offer services to area youth that are not eligible under the youth program through the One-Stop centers. However, One-Stop services for non-eligible youth must be funded by programs that are authorized to provide services to such youth. For example, basic labor exchange services under the Wagner-Peyser Act may be provided to any youth.

Additionally, Grand Island Senior High School (CNSSP), Region 3 Behavioral Health Services and NE Vocational Rehabilitation have been in partnership since September, 1999 to provide services to students ages 14-21 who are eligible for V.R. Services, Professional Partners and are served by GIHS. The targeted population are:

1. Students who are considered to be at risk in the community, school or workplace.
2. Students who are verified with disabilities (SPED or 504 eligible).
3. Students who are considered candidates for competitive employment.
4. Students who must exhibit a serious emotional disorder.

In addition to funding, Region 3 Behavioral Health Services services include professional partner service, building informal supports, mental health assessment and related needs, crisis plan development & Wraparound services. Grand Island High School services include the funding contribution, Special Ed Assessment, IEP development, facilities, networking, academic/educational services and structural and systemic accommodation. VR services besides funding include vocational assessment and counseling, job placement, job seeking skills and job retention counseling and employment related independent living skills. Services provided with cooperative funding include job coaching , job specific training, required tools, clothing, on the job training, mentoring, Transportation and miscellaneous individual accommodations necessary to employment success.

For the past four (4) years, the average number of students served each year is 8. The average age of the students have been 16 and have had a variety of Behavioral Health disorders. Each student has had professional partner and wraparound services, educational accommodations. The vocational services have included job site placement and vocational counseling. Some have started in unpaid work experiences and others in regular competitive employment. This past year VR provided a weekly group focused on job keeping skills.

This program has been extended each year, still using the original "pot" of money. The collaboration between the agencies has kept the expenditures to only what the student needs to be successful in a job placement. The partners meet monthly to review progress on students and to process new referrals.

Another program for improving employment opportunities for youth is SCOPE. SCOPE is an acronym for STUDENT CAREER OPPORTUNITES IN PERMANENT EMPLOYMENT. This is a cooperative agreement between the Lincoln Public Schools and Voc Rehab that focuses on special education students in their last year of high school classified as either having a learning disability (SLD) or behavioral disorders (BD). These are two special education

groups for which LPS has not provided employment related services to. For most of the students who participate, SCOPE places them in their first every job, provides job coaching and follow along. Approximately half of the students end up losing or quitting their job and require services again prior to or after exiting school. It is a small program as this last year it served 18 students. (for other employment, see Criteria #3).

GAP #3: LACK OF ADEQUATE "STEP DOWN" SERVICES

UPDATE – November 2004

This is looking at the flow of adults through the Nebraska Behavioral Health System (NBHS). The Governor's Behavioral Health Reform Initiative should help to improve this consumer flow through the system (See Section Two: Summary of Significant Events above). This is a major reform to improve the availability and accessibility of high-quality community-based services for people impacted by behavioral health issues including those who have or at risk for mental illnesses and their families. The Behavioral Health Reform includes the possible closure of two of the three Nebraska State Psychiatric Hospitals (Hastings and Norfolk Regional Centers) and creates more community-based programs for treating behavioral health disorders (mental health and substance abuse). It is expected that this reform will result in improved service capacity within the community mental health system. This includes the development of more "step down" services.

GAP #4: INFORMATION SYSTEM IS INADEQUATE

UPDATE – November 2004

In FY2004, the Governor's Behavioral Health Reform Initiative was passed by the Legislature (See Section Two: Summary of Significant Events above). The Act became operative on July 1, 2004. LB 1083 Section 6. (1) says the Division of Behavioral Health Services shall act as the chief Behavioral Health authority for the State of Nebraska and shall direct the administration and coordination of the Public Behavioral Health System, including, but not limited to: "(e) development and management of data and information systems".

As noted above, Richard DeLiberty started in the position of Behavioral Health Administrator for the Nebraska Department of Health and Human Services on October 18, 2004. Mr. DeLiberty was deputy director for the Indiana Division of Mental Health until 2002. He is very familiar with the various issues involved with mental health data infrastructure. Decisions on next steps with the mental health data infrastructure have been stalled pending this appointment. With Mr. DeLiberty appointed, with his background on mental health data, Nebraska should start making real progress with improving this infrastructure.

Assessment of the States' Ability to Provide Uniform Reporting System (URS) Data

At this time, Nebraska has separate reporting systems for the State Psychiatric Hospitals and the Community Based programs. Each has the capacity to provide unduplicated counts. Table 2A in the Uniform Reporting System is an unduplicated count of persons served in community mental health (from the Magellan data base) and the Regional Centers (AIMS data base used in the State Psychiatric Hospitals). For the FY2003 report, State Psychiatric Hospital data were reported separately from community data.

Progress on capacity development to report the unduplicated count has been made by HHS Finance and Support (F&S) Information Systems &Technology (IS&T) Applications Analyst staff. The staff has been working on data mapping and creating the structure needed for the federal reporting requirements of unduplicated counts across those data systems. This project continues to develop methods needed to consolidate data collected from multiple data systems into a single data repository.

The Part E Uniform Reporting System tables in this report represents the State of Nebraska's current capacity to report an unduplicated count using AIMS and Magellan data.

Full Description of the Current State Mental Health Authority Information System
The current Information System used for the Uniform Reporting System is in three parts:

- Community Mental Health Data Collection – Magellan Behavioral Health:
- State Psychiatric Hospitals (AIMS to AVATAR):
- Consumer Survey

Community Mental Health Data Collection – Magellan Behavioral Health:
The Nebraska Department of Health and Human Services (HHS) Office of Mental Health, Substance Abuse and Addiction Services has a contract with Magellan Behavioral Health for managed care Administrative Services Only (ASO) services. The contract includes the operation of the current data system used for Community Mental Health and Substance Abuse services. It also covered a portion of the three Regional Centers. The data base managed by Magellan Behavioral Health is one of the primary sources for the data used for the Federal Community Mental Health Block Grant application. Magellan Behavioral Health officially started to collect the community based behavioral health programs (mental health and substance abuse) on July 1, 1997. Community-based utilization management was initiated in December of 1997 for those services requiring authorization. With the renewed contract starting January 2000, a set of 81 mandatory data fields covering both mental health and substance abuse were specified. That data collection arrangement ended on December 31, 2002.

A new contract portion covering Nebraska Behavioral Health System (NBHS) started January 1, 2003. This contract ends June 30, 2005. The Magellan Behavioral Health data system revisions were implemented in October 2003. The revised 117 data fields for the NBHS cover

- Community mental health, community substance abuse, and the gamblers assistance program
- Sections such as demographics, admission status data, children/adolescent (0-18), history of substance abuse, service / authorization, financial eligibility, discharge status.

A key issue with the Magellan data base is discharge records for registered consumers. This is a data quality issue which needs to be systematically addressed. There are two general types of data collection under Magellan … registered and authorized.

Registered vs Authorized – Nebraska contracts though two mechanisms, i.e., for service and capacity building.

- Register – Non-fee basis is an expense reimbursement system. Agencies are paid up to a maximum stated in a contract for the purpose of operating a program or service type. These are services purchased for the capacity building, are non-fee-for-service and the data are

captured through a registration process managed by Magellan. However, payments are not contingent on the data reporting occurring.

- Authorize – Fee-for-service is Nebraska's managed care system and is a payment system based on units of service. All services under the Fee-For-Service are authorized by the Magellan Behavioral Health Administrative Services Only (ASO) contract. Data are collected as part of the authorization process.

Nebraska pays public providers either on a fee-for-service or non-fee basis. Registered consumers have services paid for on a non-fee for service basis. Authorized consumers have services paid for on a fee for service basis. Units are paid for a person and are based on fees set by the State, or the Regional Behavioral Health Authority and agreed to by the private non-profit entity providing the service. An individual receiving services paid for on a fee-for-service basis, must have the service authorized by Magellan Behavioral Health Care, Inc. -- The Nebraska public, community-based system, managed care administrative service organization.

See the tables on the HHS web site for a listing of the Nebraska behavioral health service names and their authorized or registered status http://www.hhs.state.ne.us/beh/bhsvcdef.htm.

Authorized services include Community Support services (Mental Health, Substance Abuse), Assertive Community Treatment (ACT), Acute Inpatient, Secure Residential – MH, Intermediate Residential – MH, Intermediate Residential – SA, Psych Residential Rehabilitation – MH, Short-Term Residential – SA, Halfway House – SA, Dual Residential, Therapeutic Community – SA, Day Treatment – MH, Partial Care – SA, Intensive Outpatient – MH, Intensive Outpatient – SA, Day Rehabilitation – MH, and Vocational Rehabilitation. Care Monitoring may be either authorized or registered.

Register services include Emergency 24 hour Clinician on-call / phone, Crisis Assessment/Evaluation, Mobile Crisis Intervention, Emergency Shelter –Social Detox, Emergency Shelter –Psych Respite, Emergency Community Support, Emergency Protective Custody, Civil Protective Custody, Emergency Shelter –Residential Stabilization, Outpatient Assessment/Therapy – MH, Outpatient Assessment/Therapy – SA, Psychological Testing, Medication Management – MH, Medication Management – SA Methadone, Day Support, and Vocational Support – MH.

Termination information is poorly entered among registered consumers leaving sizable gaps in the information to report. There is a significant number of registered consumers who most likely are no longer receiving services but who remain open as active cases. Magellan is working with state staff to determine how to close these cases.

State Psychiatric Hospitals (AIMS to AVATAR):
Lincoln Regional Center, Hastings Regional Center, and Norfolk Regional Center are engaged in a State Psychiatric Hospital data system conversion from "Advanced Institutional Management Systems" (AIMS) to the Creative Socio-Medics (CSM) Corporation software called "Avatar". The goal of this project is to replace existing functionality (AIMS is being discontinued) and establish a standard electronic patient record. The Avatar system will include modules that address practice management, clinician workstation, and client funds management.

Consumer Survey

The Nebraska Behavioral Health Consumer Survey is managed by the HHS Office of Mental Health, Substance Abuse and Addiction Services. This work is completed to collect the data needed for Table 11: Summary Profile of Client Evaluation of Care.

The methods were presented to and approved by the Nebraska Mental Health Planning & Evaluation Council at the Winter 2004 Meeting on February 12, 2004.

Goals of the Nebraska Behavioral Health Consumer Survey

- ✓ The goal is to receive unfiltered consumer feedback on the services purchased by Nebraska HHS Office of Mental Health, Substance Abuse and Addiction Services.
- ✓ The survey design assures anonymity of response. The data are collected, analyzed, and reported in a manner that guarantees the individual consumer responding can not be connected to a specific set of responses or comments. In other words, as a result of this approach, the surveys returned will be anonymous, confidential and will not be matched to mental health consumer databases.
- ✓ Use the data as one of the State of Nebraska Performance Measures.
- ✓ Results are available as state level comparative data for behavioral health provider use.
  - For FY2003, results were publicly posted on the HHS Mental Health Web Site http://www.hhs.state.ne.us/beh/mh/mh.htm
  under the title of "NE Implementation Report FY2003, November 2003"
  Table 11: Summary Profile of Client Evaluation of Care
  - For FY2004, the statewide results will be posted in the same manner.
- ✓ Use the data to meet the federal reporting requirements.

Federal Reporting Requirements:

- ✓ As part of the Federal Community Mental Health Block Grant requirements, the State Plan Implementation Report is submitted by the deadline of December 1 each year. Under the Uniform Reporting System is Table 11 "Summary Profile of Client Evaluation of Care". This table provides a summary of key indicators of client evaluation of mental health services purchased by the State Mental Health Authority.
- ✓ Based on Federal Community Mental Health Block Grant reporting requirements, by Fall 2004, the Nebraska Consumer Survey needs to include the Youth Services Survey, the one designed for Families and the Adult 28 item survey.
- ✓ Use the Official Federal MHSIP consumer survey. For more information on the federal Center for Mental Health Services (CMHS) Mental Health Statistics Improvement Program (MHSIP) see "Consumer Surveys" under <**http://www.mhsip.org/**>.
  - ~ The Official MHSIP Adult Survey -- 28 item
  - ~ Final MHSIP Youth Services Survey (YSS)
  - ~ Final MHSIP Youth Services Survey For Families (YSS-F)
- ✓ Federal reporting requirements include the expectation that the Confidence Interval and Confidence Levels of the consumer Survey be reported.

Scope and Design of the Project

- ✓ Annual Mail Survey
- ✓ For FY2004, will use only a “Mail Survey”

- ✓ The design will guarantee the surveys returned are anonymous.

Method – to be structured by the natural boundaries:

- ✓ Limited to Nebraska Behavioral Health System (NBHS). This includes the contractors and sub-contractors with the HHS Office of Mental Health, Substance Abuse and Addiction Services (Regional Governing Boards and behavioral health providers).
- ✓ Work to the program level only (Mental Health, Substance Abuse).
- ✓ Do not survey at the service level (e.g., outpatient, community support, emergency services)
- ✓ Random sample is used of persons served from January 1, 2004 to March 31, 2004 who have a reported address in the Magellan Behavioral Health data base.
- ✓ Broken out by adult and youth services.
- ✓ Gamblers Assistance Program is excluded in FY2004.
- ✓ Substance Abuse Detox programs excluded in FY2004.
- ✓ Use of the "George Hanigan, Deputy Director" postage paid envelop (business reply mail).
- ✓ Request incorrect addresses be returned to HHS
- ✓ HHS generates list of names using the Magellan data set received in Mid-April 2004.
- ✓ HHS (see below) mails out the survey, completes the data entry, reports the results.

Data collection time period needs is completed no later than September 30 of each year. Last day of data entry for FY2004 reporting will be October 1, 2004

- ✓ Summary of behavioral Health consumer Survey mailings for FY2004

source: Jim Fick, Wagon Wheel Industrial Center

4,426	7/1/04- 1st mailing Adult survey
590	7/1/04- 1st mailing Youth surveys
4,147	7/16/04- 2nd mailing Adult 1st reminder
552	7/16/04- 2nd mailing youth 1st reminder
4,087	8/2/04- 3rd mailing Adult 2nd reminder
541	8/2/04- 3rd mailing youth reminder
26	8/2/04- surveys by request to OMSA
24	8/20/04- surveys by request to OMSA

- ✓ Surveys Returned due to bad addresses

636	Adult
48	**Youth**

The work is completed by:

- ✓ Overall project management from Jim Harvey
- ✓ The Use of federal funds Mental Health Data Infrastructure Grant for direct costs from the Lincoln Regional Center's Wagon Wheel Industrial Center. This is a program designed to provide employment opportunities for the patients at the Lincoln Regional Center, one of Nebraska's State Psychiatric Hospitals. Wagon Wheel prepares and mails the survey. After the consumer completes the survey, it is returned directly to HHS by postage paid envelop. The envelops are opened by the consumer employees of the Wagon Wheel Industrial Center. Then they completed the data entry.
- ✓ Data analysis for Table 11 to be completed by Paula Hartig, Program Analysis & Research Administrator in HHS-Finance & Support / Financial Services - Research & Performance

Measurement. Ms. Hartig is a state employee and is part of the State Match used under the MH DIG grant.

The Statewide Summary of the consumer survey is on Table 11 of the Uniform Reporting System.

GAP #5: SHORTAGE OF CREDENTIALED & ADMINISTRATIVE STAFF

UPDATE – November 2004

There is a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, licensed mental health practitioners (LMHP), nurses and Licensed Alcohol/Drug Abuse Counselors (LADAC).

The Governor's Behavioral Health Reform Initiative was passed by the Legislature (See Section Two: Summary of Significant Events above). Part of this includes work on addressing these shortages. This is important because of the increasing expectations on what the Nebraska Behavioral Health System (NBHS) needs to address. Below provides an example of how these work force issues will be addressed. This material is from the Nebraska Health and Human Services Adult Behavioral Health Reform Web site <http://www.hhs.state.ne.us/beh/reform/plan.htm>

ID	Code	Subject
200	S6.1(j)D1	S6(1j) Deliverable 1: Workforce development plan
201	S6.1(j)D1A1	Develop documents listing Behavioral Health providers and training programs
202	S6.1(j)D1A2	Gather relevant data - graduate student at UNO School of Social Work - funded by SAMHSA grant in OMHSAAS. Supervised by faculty at UNO
203	S6.1(j)D1A3	Coordinate with Health Professions Tracking Center at UNMC
204	S6.1(j)D1A4	Coordinate with workforce committee in Rural Health Advisory Commission (co-occurring)

GAP #6: MEDICATION ACCESS

UPDATE – November 2004

This gap involves many things related to providing access to psychiatric medications for persons with serious mental illness or youth with severe emotional disturbance. Medications are a part of recovery for most people diagnosed with serious mental illnesses. One of the SAMHSA Evidence-Based Practices (EBP) is Medication Management. It involves the systematic use of medications as a part of the treatment for schizophrenia. For more information see <http://www.mentalhealthpractices.org/se.html>.

Nebraska is paying for medications. Here are two examples:

- One source to pay for psychiatric medications is "LB95". This is an indigent outpatient, prescription medicine program administered by the Department of Health and Human Services. It is authorized under Neb. Rev. Stat. §83-380.01 (Laws 1981, LB 95, § 25). The authorized

consumer is indigent, receiving outpatient medications, and has a history of commitment to inpatient level of care. The Community Mental Health Funding via the Office Of Mental Health, Substance Abuse and Addiction Services" line item "Indigent Medications" (through Regional Centers) was $600,000 in FY2003.

- For the National Association of State Mental Health Program Directors Mental Health Expenditures and Revenues report for 2002, on Table 4, Nebraska reported for FY 2002 Expenditures for Psychiatric Medications and "Atypical" Antipsychotics in the Community Mental Health Programs the Medicaid funds including state match for total pharmacy was $55,412,280.

GAP #7: CULTURALLY COMPETENT SERVICES

UPDATE – November 2004

A critical service gap in the adult and children's mental health system appears to be cultural and linguistically competent services. A language barrier has arisen in several communities across Nebraska, rural and urban, due to the increase in minority populations living across the state. There is lack of access to bi-lingual mental health professionals and family support services. Services which recognize the unique cultural needs of all Nebraskans are not always available. This lack of access should be recognized and culturally competent services should be developed. The new immigrant/refugee populations (such as the people who are Vietnamese or Somali) in Nebraska also needs to be addressed.

At the November 10, 2004 review of this Implementation Report, the members of the State Advisory Committee on Mental Health Services made a special note that this gap of Cultural Competent Services needs to be better addressed. Committee member Maria Prendes-Lintel said there needs to be a specific set of goals, objectives and activities designed to address these issues. She noted there are many issues involved here including not having enough qualified interpreters. A bad interpreter can make things worse for the consumer. Competency includes knowledge of medications because different groups react differently to the various medications. Committee member Nancy Kratky noted the Omaha Public Schools have students speaking 38 different languages from 50 different countries.

Here is a summary of the Number of Persons Served by Race in FY2004 compared to the Total Nebraska Population by Race.

	Total NE Population	
	#	%
American Indian or Alaska Native	14,896	0.9%
Asian	22,767	1.3%
Black or African American	68,541	4.0%
White	1,533,261	89.6%
Other Race	71,798	4.2%
Total	1,711,263	100.0%

The data are from the Uniform Reporting System 2004 Report

- Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

	Table 2A		table 14A	
	#	%	#	%
American Indian or Alaska Native	536	2.9%	147	2.1%
Asian	68	0.4%	23	0.3%
Black or African American	807	4.4%	257	3.6%
Native Hawaiian or Other Pacific Islander	10	0.1%	2	0.0%
White	14732	80.1%	5,707	80.5%
More Than One Race Reported	1284	7.0%	712	10.0%
Race Not Available	959	5.2%	241	3.4%
Total	18,396	100.0%	7089	100.0%

The table below shows the number of unduplicated persons served who consider themselves to be Hispanic or Latino. Based on the 2004 Table 2B "Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity"

The data are from the Uniform Reporting System 2004 Report

- Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
- Table 14A. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

	Table 2B		Table 14B	
Not Hispanic or Latino	16,516	89.8%	6394	90.2%
Hispanic or Latino	938	5.1%	226	3.2%
Hispanic or Latino Origin Not Available	942	5.1%	469	6.6%
Total	18,396	100%	7089	100%

GAP #8: ELDERLY POPULATION NOT BEING SERVED…

UPDATE – November 2004

Another important gap exists in mental health services to elders. The table below shows that in FY2004, people who were age 65 or older, there were Table 2A shows 537 (3.2%) unduplicated count of persons served and Table 14A shows 247 adults with serious mental illness.. The Nebraska Census Data (FY2000) shows the people age 65 years and over equals 232,195 (13.6%).

	Persons Served		Nebraska Census Data – 2000
	Table 2A	Table 14A	#
65-74 years	342	176	115,699
75+ years	195	71	116,496
Total age 65+	537	247	232,195
Total all ages served / Population	18,396	6,816	1,711,263
% Age 65+ Served / population	2.9%	3.6%	13.6%

NOTE: The total persons served (18,396) for 2004 is less than what was reported for Table 2A in the FY2003 report (19,865). This does not show a cut in the number of persons served. Starting FY2004, it does reflect an improved capacity to report unduplicated persons served between the community mental health (Magellan data) and the Regional Centers (AIMS Data for the State Psychiatric Hospitals. This is a new system for completing the data analysis for the Federal Uniform Reporting System that has been implemented in Nebraska. The FY2002 and FY2003 Uniform Reporting System data are subject to revision based on the new approach in data analysis.

This improved capacity was discussed in GAP #4: INFORMATION SYSTEM IS INADEQUATE.

SECTION THREE:
ADULTS– ACCOMPLISHMENTS
FY2004 GOALS FOR ADULTS

From the …
Nebraska FY2004 Community Mental Health Services Block Grant Application

ADULT GOAL #1: STRATEGIC PLANNING
ACHIEVED

ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS
ACHIEVED

These two goals were addressed as one under the Governor's Behavioral Health Reform Initiative.

- ADULT GOAL #1: STRATEGIC PLANNING - Consistent with the Governor's priority on mental health and LB 724, implement Strategic Planning to Improve the Quality and Delivery of Services provided by the Nebraska Behavioral Health System.
- ADULT GOAL #2: CONTINUE TO IMPROVE QUALITY, DELIVERY OF SERVICES AND CONSUMER ACCESS - Consistent with the Governor's priority on mental health and LB 724, continue to improve consumer access to the services provided by the Nebraska Behavioral Health System (NBHS).
  - Improve continuity of care within the requirements of HIPAA
  - For persons with serious mental illness, including transitioning young adults, develop coalitions to promote community based care under Olmstead.
    - ~ Housing
    - ~ Employment

This goal is consistent with the Governor's priority on behavioral health reform and LB 1083. Below represents a summary of key points to illustrate the work to be completed under Adult Goal #1: Behavioral Health Implementation Plan. The complete 208-page Behavioral Health

Implementation Plan and other information regarding implementation of LB 1083 can be accessed at the HHSS website at http://www.hhs.state.ne.us/beh/reform/.

LB1083 is directing all of the planning work on Behavioral Health. HHSS will partner with the Behavioral Health Regions, community-based providers, mental health consumers, and other stakeholders to ensure that the Behavioral Health Implementation Plan is comprehensive and includes local recommendations on what services are needed. For example, as the needs of Nebraska as a whole were considered, HHSS worked diligently with the Regions to develop their Phase I recommendations.

Better use of scarce resources
Behavioral Health Reform creates new, additional funding to invest in a wider array of community-based behavioral health services. For example, by moving services from the Regional Centers into the community, it becomes possible to leverage state general funds to access approximately $9 million in previously unavailable federal Medicaid funds.

The Behavioral Health Implementation Plan contemplates the initial infusion of an additional approximately $48.5 million to the public behavioral health system in Nebraska as follows:
(1) $29 million in funding redirected from regional center services to the community;
(2) $9 million in additional Medicaid funding;
(3) $2 million in funding for rental assistance for adults with serious mental illness (administered by the NE Department of Economic Development);
(4) $2.5 million in funding for emergency psychiatric services; and
(5) $6 million in one-time funding for the statewide development of community-based services. These one-time funds are allocated to the Regions under a separate Behavioral Health Reform contracts.

Implementation timelines and the actual amount of additional funding for the system depends on progress made in the transition of persons from Hastings Regional Center (HRC) and Norfolk Regional Center (NRC) to appropriate community-based or other regional center services. Delays in such progress will diminish the amount of available funding. The plan assumes that the Hastings Regional Center will be transitioned first. Available additional funding would be allocated to each behavioral health region based on population.

Balancing Intent, Schedule, and Budget
One of the purposes of LB1083 is to transition consumers from Regional Centers to community-based services (LB 1083 Section 2(7)). When determining the schedule for this project, the timing of moving of Regional Center appropriations plays a major part.

The vision for this project outlines the approach that will be taken to get to the Regional Center transitions specified in LB 1083.

> "Consumers who need more intense levels of mental health and/or substance abuse services are served closer to their home communities, support systems, family and friends in the least restrictive environment that provides safety and protection for the individuals and the community."

In short, the focus for accomplishing Regional Center transitions is on developing the community services that will replace the need for the State Psychiatric Hospitals at Hastings and Norfolk. To

ensure that the focus remains on developing the necessary community services, dates for Regional Center transitions have not been established.

The Behavioral Health Reform focus is on people who would have been served at a state-owned Regional Center – persons committed by Mental Health Commitment Boards for involuntary treatment. Approximately 700 individuals are committed to the Hastings and Norfolk Regional Centers each year.

LB1083 Section 10 requires that appropriate community-based services be available before Regional Centers are closed. Section 10 (6) says when the Regional Centers reach 20% of their licensed psychiatric bed capacity as of March 15, 2004 (see Criterion 1, Regional Center Capacity), HHSS will notify the Legislature and the Governor. A majority vote by the Executive Board of the Legislative Council will allow for transfer of the remaining patients when appropriate community-based services are available.

The financial realities of implementing LB 1083 are that the budget to maintain the necessary community services comes from future Regional Center budgets. Thus, there is incentive to establish the community services in a time frame that creates a logical balance point between the need to transition Regional Center consumers to the community and the obligation to fund existing Regional Center services. The dates of transition depend on the Centers reaching 20% of acute/secure capacity. It is not yet known when the redirection of Regional Center funds will occur.

Therefore, the funding allocation plan is laid out in six scenarios. These options have been prepared as part of the Implementation Plan. These examples show how the amount of funding available for the development of community based services decreases the longer services are provided in a Regional Center setting. The following chart illustrates several options for closure or redesign of the Hastings and Norfolk Regional Centers and the projected savings associated with each option.

Summary of Regional Centers Appropriation / Available for Redirection to Community-Based Services [Hastings Regional Centers (HRC) / Norfolk Regional Centers (NRC)]

	SFY 2005	**SFY 2006**	**SFY 2007***
Option #1			
HRC savings / transition Oct 04	8,250,455	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	**$8,250,455**	**$22,965,099**	**$29,048,008**
Option #2			
HRC savings / transition Oct 04	8,250,455	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756
total savings	**$8,250,455**	**$17,407,515**	**$29,048,008**
Option #3			
HRC savings / transition Dec 04	6,760,921	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	**$6,760,921**	**$22,965,099**	**$29,048,008**
Option #4			
HRC savings / transition Dec 04	6,760,921	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756

	SFY 2005	SFY 2006	SFY 2007*
total savings	**$6,760,921**	**$17,407,515**	**$29,048,008**
Option #5			
HRC savings / transition Feb 05	5,156,785	12,375,252	12,375,252
NRC savings / transition Dec 05	0	10,589,847	16,672,756
total savings	**$5,156,785**	**$22,965,099**	**$29,048,008**
Option #6			
HRC savings / transition Feb 05	5,156,785	12,375,252	12,375,252
NRC savings / transition Mar 06	0	5,032,263	16,672,756
total savings	**$5,156,785**	**$17,407,515**	**$29,048,008**

SFY = State Fiscal Year

Estimated Regional Center Appropriation

	General Funds	Federal Funds/Cash	total
Hastings Regional Center	11,049,349	1,325,903	12,375,252
Norfolk Regional Center	14,840,533	1,832,223	16,672,756
Total	**$25,889,882**	**$3,158,126**	**$29,048,008**

Total appropriations for the three regional centers for FY 03 were $63,396,823 ($52,197,456 General funds; $6,834,283 federal funds; and $4,365,084 cash funds).

Source: Legislative Fiscal Office as reported at the Behavioral Health Oversight Commission of the Legislature, Health and Human Services Committee at Hruska Law Center, Lincoln, NE on July 9, 2004 (slide 33).

Citizens needing behavioral health services receive more appropriate care

LB 1083 will provide more appropriate services for people with behavioral health issues. Consumers will be served closer to their home communities, and live more independent lives with more support. They will be closer to their health care providers, support groups, family and friends in the least restrictive environment that still provides safety and protection for the individuals and the community.

LB 1083 addresses the lack of behavioral health services once individuals no longer need the hospital-based inpatient services provided at Regional Centers or local hospitals. The new community-based system will include many levels of services. Consumers requiring crisis stabilization will access enhanced crisis center services. Community hospitals throughout the state will be able to develop acute psychiatric inpatient and secure residential services with the capacity to have locked units and highly trained staff. Residential rehabilitation services are less restrictive and more appropriate for some persons. Other non-residential community programs can provide services and reduce re-hospitalization. Regional Center beds will stay in place for individuals with high needs, and to provide specific care, such as the sexual offender and forensic programs.

HHSS has partnered with each of the Behavioral Health Regions to ensure that appropriate community-based services are in place statewide. Community-based services may range from intensive, hospital-level care to a secure, specialized wing of a nursing home, other residential facility, or day rehabilitation program.

Because a high percentage of the commitments to the Norfolk and the Hastings Regional Centers come from Region VI, a facility is being planned for the Omaha metropolitan area. It is referred to

in the plan as the Community Resource Center (CRC). The purpose of the Community Resource Center is not to substitute Regional Center beds, but to build an array of services that provide alternatives to long-term Regional Center placement, to support mental health research and to provide education to health care professionals in training. Private funding is being sought to create the CRC in either a new or an existing building. The CRC will be designed as part of a community hospital in order to be eligible for Medicaid funds.

This reform plan includes a collaborative effort between the medical centers at Creighton University and the University of Nebraska to provide behavioral health training, research, and clinical services and a program to provide professionals to serve rural Nebraska. This critical partnership will enable Nebraska to move to a prominent position as a leader in mental health service delivery and a model of statewide recovery-based services.

Stakeholder Involvement

HHSS provided information or briefings to a wide variety of individuals and organizations that have an interest in the behavioral health system. The extensive involvement of those stakeholders in planning, problem solving, and decision-making will continue as a key component of Behavioral Health Reform. Stakeholders include those individuals effecting the change, as well as those impacted by it.

- In the fall of 2001, HHSS began a process for identifying the housing needs of behavioral health consumers. With the introduction of LB 1083 HHSS expanded the involvement of consumers, providers, Regions, developers, and others in the process. Representatives of the "affordable housing" industry have been working closely with HHSS to develop strategies to address the requirements of LB 1083
- Starting with the January 18, 2001 meeting of the Mental Health Planning & Evaluation Council, Jeff Santema, Legal Counsel for the Legislature's Committee on Health and Human Services presented and received comments on various phases of the behavioral health reform initiatives. For example, on January 18, 2001, Mr. Santema did a presentation on LB682.
- State Senator Jensen, Legislative staff, and representatives of HHSS met with consumers, providers, state Regional Center employees, government officials, county board, mayors, and law enforcement in September and October 2003. Meetings were held in each of the state's six regions and in the Hastings, Norfolk, and Lincoln Regional Centers.
- Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. This included the Mental Health Housing Planning Steering Committee Meetings which were held on 12/11/02, 02/07/03, 04/04/03, 05/09/03, 06/23/03, 06/26/03, 07/15/03, 08/01/03 and 10/03/03.
- November 19, 2003: in Lincoln, the Nebraska Mental Health Housing Summit was held. There were 165 participants. The primary focus was to publicly share the findings from the Mental Health Housing Planner Contract with HANNA:KEELAN ASSOCIATES, P.C. & next steps in housing capacity development. The Governor made some opening remarks. State Senator Jim Jensen also spoke. Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance for the Mentally Ill was the Keynote speaker. A special video was prepared showing interviews where consumers discuss their housing needs.
- November 19, 2003: Governor's news conference to announce behavioral health reform. Governor briefed representatives from the Hastings and Norfolk Communities and state senators that day.

- Ron Ross, former Director of HHS, met with consumers, Regional Program Administrators (RPA) and providers in all regions in November and December 2003 to discuss issues with closing Regional Centers.
- Governor Johanns met with law enforcement on December 9, 2003 and the Norfolk and Hastings communities several times throughout November and December 2003 and January 2004.
- Governor Johanns met with consumers and providers December 16, 2003, to identify and discuss their issues with the behavioral health reform.
- On January 23, 2004, HHSS met with all RPAs and law enforcement representatives to formally initiate the community planning process. HHSS provided guidelines for the planning for the development the community services necessary to treat patients needing acute and secure services in the community.
- March 2-10, 2004: Governor, HHSS and Regional Program Administrators briefed state senators on state and regional behavioral health system and behavioral health reform planning.
- From January to March Regional representatives met with consumers, Regional Center representatives, community providers, County Board members, law enforcement officials, District Attorneys, and many other stakeholders to gather input and develop community service plans necessary to implement LB 1083.
- On March 31, 2004 the six Regions presented their proposed Phase I plans to HHSS on replacing inpatient services at Hastings and Norfolk Regional Centers with community hospital services; serving persons ready for discharge from all three Regional Centers; and developing additional emergency services. Phase II plans, due December 31, 2004, will focus on long-term expansion of community-based services
- Representatives of HHSS continued the planning process in June 2004, meeting with Regions and providers to continue to collect input and to identify emerging issues.
- The extensive involvement of stakeholders in planning, problem solving, and decision making will continue as a key component of behavioral health reform. Consumers and consumer organizations, providers, law enforcement, hospitals, representatives of the legal system, county boards and other elected officials will be participants in the planning and implementation process at both the state and community level.

Behavioral Health Implementation Plan

LB1083 sections 19-20 establish important requirements on the Division preparing and submitting a Behavioral Health Implementation Plan. On July 1, 2004, HHSS submitted the LB 1083 Behavioral Health Implementation Plan to Governor Johanns and the Nebraska Legislature per sections 19-20. The complete 208-page Behavioral Health Implementation Plan and other information regarding implementation of LB 1083 can be accessed at the HHSS website at http://www.hhs.state.ne.us/beh/reform/. The Plan sets out:

- the approach HHSS took in planning for Behavioral Health Reform,
- the scope of the implementation plan, and
- the specific activities that HHSS will undertake to accomplish reform.

The details of the work make it clear that LB 1083 will result in more appropriate behavioral health services for people through a better use of scarce resources.

This plan focuses on two core values central to the implementing legislation:
1) Citizens in need of behavioral health services will receive more appropriate care; and
2) The new behavioral health system will make better use of scarce resources.

The HHSS recommendations for the Region Replacement Services and Funding were based on 22 Assumptions. Some of the key assumptions included:

- The priority FOCUS for all decisions is:
  a) Replacing current capacity in HRC and NRC
  b) Moving current NRC and HRC consumers into community housing and services
  c) Reducing commitments, reducing emergency protective custody holds and elimination of post-commitment days in the Regions
- Decisions are based on assumption that HRC services will transition to the community first.
- Decisions are based on timeframes and cash flow availability to move Regional Center state funds to community-based services.
- This plan does not solve all system capacity problems.
- Priority is given to less intensive services in community-based settings.
- Recommendations for discharge placements focused on least restrictive settings and assumed stable independent housing.

State Priorities

The plans and funds appropriated to the behavioral health (mental health and substance abuse) system are specifically intended to serve the adult population and to directly impact the following state priorities:

Phase I: Regional Center REPLACEMENT Services. The regions submitted plans on March 30, 2004.

Priority A – **REPLACEMENT** services to replace current HRC/NRC acute inpatient and secure subacute residential services

Priority B – **DISCHARGE READY** services for persons currently being served in the HRC/NRC/LRC

Priority C – **EMERGENCY SERVICE** development and/or restructuring to reduce EPCs and commitments in the regions.

Phase II: Expansion of Community Based Services to Impact Reduction in Need for Acute and Secure services. The regions will submit plans by December 31, 2004.

Priority A: **NON-RESIDENTIAL SERVICE** development and/or expansion to reduce use of acute inpatient and secure subacute residential services, and increase community tenure in the least restrictive setting with stable housing.

Behavioral Health Region Plans: Phase I

The first section of the Behavioral Health Implementation Plan outlines the development of services and necessary funding for each Region of the state. The six Behavioral Health Regions assessed the needs of each Region and submitted plans on March 30, 2004 to meet those needs through community-based services. The Nebraska Department of Health and Human Services System compiled and refined the regional plans to maximize resources from a statewide perspective and match the services with the specific needs of the consumers served by Regional Centers.

The funding is allocated based on the anticipated costs associated with the specific types of services needed to meet the Phase I priorities in each Region of the state. Additionally, the funding level is influenced by the average length of time a service is needed by the consumer.

Phase I priority service development and funding is as follows:

- In Region 1, the Panhandle, reliance on Regional Center care is minimal with 93% of mental health board commitments served by hospital level community based services and coordination of services provided by the Homeward Bound Project. Behavioral health services to be expanded include adding crisis response services for communities not currently served by Local Crisis Response Teams, increasing emergency crisis capacity and providing assisted living support services at a cost of approximately $1.1 million dollars.
- In Region 2, west central Nebraska, reliance on Regional Center care has been moderate with all persons committed within the last 4 months served at local hospital level community based services. Local crisis response services will be expanded, as will residential services and supportive services at a cost of $1.6 million.
- In Region 3, south central Nebraska, reliance on Regional Center care has traditionally been heavy as the region has the highest per capita commitment rate in the state. Existing hospital-level community-based services, community residential, support services and an emergency crisis stabilization unit will be utilized to serve consumers at a cost of approximately $4 million (including one time start up costs). This shift in services is projected to decrease commitments and increase services being provided in the community.
- In Region 4, a large geographic area in northeast and north central Nebraska containing mainly rural/frontier counties, heavy reliance on the Norfolk Regional Center traditionally has been the case. Additional acute and secure services at the community hospital level will be developed in addition to expanding residential and support services. Furthermore, crisis stabilization to serve about 50 persons and rural crisis response teams to serve 160 persons will be developed at a cost of approximately $3 million.
- In Region 5, southeast Nebraska, reliance on Regional Center acute, secure, and long-term residential services for the difficult to serve population, has generally been heavy. The Region annually serves approximately 220 consumers committed to acute and/or secure services and provides emergency protective custody (EPC) involuntary crisis stabilization services to over 800 consumers. The region has 24% of the population in the state with 31% of the state's EPC cases. Approximately 30% of committed individuals come from rural Region V. In Phase I, Assertive Community Treatment (ACT) team services (capacity of 70), will be developed and directed towards consumers discharged from the Regional Centers. The emergency system will be expanded by funding rural emergency crisis response teams and emergency support services. Phase I services will cost approximately $1.4 million.
- In Region 6, eastern Nebraska, the development of a Community Resource Center (CRC) will be the primary focus to co-locate emergency services and acute inpatient and secure subacute services. In FY03 Region VI committed 185 people to the Norfolk Regional Centers which constituted 75% of the commitments to that facility. 48% of commitments could have been served at a secure subacute level of care that is not currently available in Region VI. The CRC will provide a twenty-four hour emergency crisis center designed to further reduce the reliance on commitments for Regional Center services. Existing services and funding will be realigned and combined with expanded funding for the CRC. The creation of an additional Assertive Community Treatment (ACT) team, serving up to 70 consumers, will provide expanded community based treatment, rehabilitation and support services for the long-term hard to serve population from the Regional Centers. Phase I services will cost approximately $6 million.

Summary for the funding of Phase I Services / Approximate Costs in million dollars

Region	1	2	3	4	5	6	Total
	$1.10	$1.60	$4.00	$3.00	$1.40	$6.00	$17.10

Project Timeline

Apart from the timing of the Regional Center transitions, the majority of the deliverables and activities in the work breakdown structure can be scheduled. The scheduling of activities and tasks is dependent on available resources, priorities of deliverables, and dependencies between deliverables. A portion of the HHSS Behavioral Health Reform Implementation Plan / Work Breakdown Structure Deliverables Only is listed below. The complete nine page document of "Deliverables Only" can be found at http://www.hhs.state.ne.us/beh/reform/docs/ImpPlan/WBS_Deliverables_Only.pdf

ID	Code	Subject	Status	Responsible Person	Assigned Staff
1	S5D1	S5 Deliverable 1: An Administrator for the Division of Behavioral Health Services	Due 9/30/2004		
12	S5D2	S5 Deliverable 2: A Chief Clinical Officer for the Division of Behavioral Health Services	Due 11/30/2004		
22	S5D3	S5 Deliverable 3: Office of Consumer Affairs (OCA)	Due 8/31/2004		Thomas
29	S5D4	S5 Deliverable 4: Program Administrator of Office of Consumer Affairs	Due 9/30/2004	Thomas	
39	S5D5	S5 Deliverable 5: Separate budget and method of accounting for revenues and expenditures for the Division of Behavioral Health Services	Completed	Bouwens	Pope
42	S6.1(a)D1	S6(1a) Deliverable 1: List of Rules and Regulations (R&R) for Division of Behavioral Health Services	Due 12/31/2004	Bansal	Staley
44	S6.1(a)D2	S6(1a) Deliverable 2: Operating Policies for Division of Behavioral Health Services	Due 12/31/2004	Sorensen	Thomas
51	S6.1(a)D3	S6(1a) Deliverable 3: List of existing Division provided services and locations, including Regional Centers (RC), and including brief descriptions	Due 7/31/2004	Sorensen	
56	S6.1(a)D4	S6(1a) Deliverable 4: List of proposed Division provided services and locations, including RCs, and including brief descriptions	Completed	Sorensen	
61	S6.1(a)D5	S6(1a) Deliverable 5: Roles and functions of Division of Behavioral Health Services	Due 9/30/2004	Sorensen	
67	S6.1(a)D6	S6(1a) Deliverable 6: Organizational chart for the division, including regional centers	Completed	Sorensen	
73	S6.1(b)D1	S6(1b) Deliverable 1: Integration plan	Due 12/31/2004	Sorensen	

ID	Code	Subject	Status	Responsible Person	Assigned Staff
83	S6.1(c)D1	S6(1c) Deliverable 1: Comprehensive statewide plan (Annual-not 1083 plan) [Section 10(1) has details]	Due 6/30/2005 and annually		
95	S6.1(d)D1	S6(1d) Deliverable 1: Role and functions of Regional Behavioral Health Authorities (RBHA)	Due 12/31/2004	Hanigan	Sorensen
113	S6.1(d)D2	S6(1d) Deliverable 2: Regional Budgets	Due 6/30/2005	Sorensen	
126	S6.1(d)D4	S6(1d) Deliverable 4: Audit BH Programs and Services	Due 12/31/2005 and annually		
133	S6.1(e)D1	S6(1e) Deliverable 1: Management information system	Due 12/31/2005	Gamet	
141	S6.1(e)D2	S6(1e) Deliverable 2: Decision/process to "Track" patients discharged from Regional Centers (RC)	Completed	Gamet	
146	S6.1(e)D3	S6(1e) Deliverable 3: Bid and Negotiate Vendor Contract for prior authorization support	Due 6/30/2005 and annually		
150	S6.1(f)D1	S6(1f) Deliverable 1: Reimbursement Process	Due 12/31/2004		
161	S6.1(f)D4	S6(1f) Deliverable 4: Financial Eligibility policy/sliding fee scale/consumer co-pay	Due 12/31/2004		
169	S6.1(f)D5	S6(1f) Deliverable 5: Statement of Priorities	Due 9/30/2004	Sorensen	
175	S6.1(g)D1	S6(1g) Deliverable 1: List of professions, services, and facilities to be credentialed by R&L	Due 9/30/2004	Sorensen	
181	S6.1(g)D2	S6(1g) Deliverable 2: A cooperative agreement between R&L and HHS	Due 12/31/2004	Sorensen	
187	S6.1(h)D1	S6(1h) Deliverable 1: Revise cooperative agreement with F&S	Due 12/31/2004	Seiffert	Seiffert
190	S6.1(h)D2	S6(1h) Deliverable 2: List of Medicaid covered BH services	Completed	Seiffert	Brady Cygan
193	S6.1(i)D1	S6(1i) Deliverable 1: Audit Procedures	Due 12/31/2004	Wittmuss	
200	S6.1(j)D1	S6(1j) Deliverable 1: Workforce development plan	Due 7/15/2004	Shaffer	Shaffer
205	S6.1(j)D2	S6(1j) Deliverable 2: Best Practices	Due 9/30/2004	Shaffer	Shaffer
213	S6.1(j)D3	S6(1j) Deliverable 3: Clinical and educational tele-behavioral health	Due 1/31/2005		
218	S6.1(j)D4	S6(1j) Deliverable 4: Grant applications consistent with reform project	Due 12/31/2005	Shaffer	Shaffer
224	S6.1(j)D5	Section 6(1j) Deliverable 5: Training curricula	Due 12/31/2005	Shaffer	Shaffer
230	S6.2D1	S6(2) Deliverable 1: List of all regulations to be created or amended to implement LB 1083	Due 7/31/2004	Bansal	Staley
234	S8D1	S8 Deliverable 1: Guidance to RBHA to meet LB1083 requirements	Due 7/31/2004	Hanigan	Sorensen

ID	Code	Subject	Status	Responsible Person	Assigned Staff
238	S8D2	S8 Deliverable 2: HHSS provides all 6 region reports to oversight commission	Due 8/31/2004	Hanigan	Sorensen
252	S8D3	S8 Deliverable 3: Certification of county matching funds	Due 8/31/2004	Hanigan	
257	S9D1	S9 Deliverable 1: Rules and Regulations (R&R) for the development and coordination of BH services	Due 3/31/2005		
262	S9D2	S9 Deliverable 2: R&R for the provision of BH services	Due 3/31/2005		
267	S9D3	S9 Deliverable 3: Policy for the provision of services by RBHAs	Due 12/31/2004	Hanigan	Sorensen
272	S10(1)D1	S10(1) Deliverable 1: Statewide Community BH Services Plan for July 1, 2004.	Completed	Hanigan	
311	S10(1)D2	S10(1) Deliverable 2: List of services and capacities to be provided by Regional Centers (RC).	Due 8/31/2004	Hanigan	Sorensen
325	S10(1)D3	S10(1) Deliverable 3: List of BH Services and definitions	Due 12/31/2004	Sorensen	Wittmuss
335	S10(1)D4	S10(1) Deliverable 4: Effective authorization environment	Due 12/31/2004	Sorensen	Wittmuss
343	S10(1)D5	S10(1) Deliverable 5: Quality improvement plan and process for services and transition of consumers.	Due 12/31/2005	Sorensen	
350	S10(1)D6	S10(1) Deliverable 6: Final methodology and payment rates for all BH reform services	Due 12/31/2004	Hanigan	
377	S10(1)D7	S10(1) Deliverable 7: Medicaid State Plan Amendments (SPA) or waivers as needed submitted to CMS	Due 12/31/2004	Seiffert	Brady Cygan
388	S10(1)D8	S10(1) Deliverable 8: Plan for increased supportive employment opportunity for consumers	Due 2/28/2005	Medinger	Medinger
397	S10(1)D9	S10(1) Deliverable 9: Expanded employment services for target population	Due 6/30/2005	Harvey	Harvey
399	S10(1)D10	S10(1) Deliverable 10: Regional contracts for services between state and Regions	Due 10/31/2004 and annually		
405	S10(1)D11	S10(1) Deliverable 11: Contracts or agreements with providers for services not provided through the Regions	Due 4/30/2005	Thomas	
414	S10(2)D1	S10(2) Deliverable 1: Expenditures by Regional Centers are managed so sufficient HRC/NRC funds are available to fund community services so commitments are diverted to the community.	Due 12/31/2005	Hanigan	Sorensen
433	S10(3)D1.3	S10(3) Deliverable 1.3: HHSS Criteria to make determination recommendation to Governor	Due 8/31/2004	Sorensen	
500	S10(6)D2	S10(6) Deliverable 2: Regional Center Assessment Tool	Due 7/31/2004	Shaffer	Shaffer
506	S10(6)D3	S10(6) Deliverable 3: Contracts with Transition Coordinators and Project Manager	Due 8/31/2004	Sorensen	
516	S10(6)D4	S10(6) Deliverable 4: Transition Team Trained	Due	Thomas	

ID	Code	Subject	Status	Responsible Person	Assigned Staff
			9/30/2005		
527	S11D1	S11 Deliverable 1: Allocation plan for distribution of funds to the Regional Behavioral Health Authorities (RBHAs)	Due 7/31/2004 and annually		
533	S11D2	S11 Deliverable 2: Integrated budget	Due 3/31/2005	Bouwens	
543	S11D4	S11 Deliverable 4: Information regarding number of people served/by service/by cost	Due 9/30/2004	Sorensen, Hanigan Division	
546	S13-16D1	S13-16 Deliverable 1: Recommendation on committee members for State Advisory Committees on Mental Health Services, Substance Abuse Services, and Problem Gambling and Addiction Services	Completed	Sorensen	
551	S13-16D2	S13-16 Deliverable 2: Draft document of by-laws	Due 10/31/04	Sorensen	
556	S13-16D3	S13-16 Deliverable 3: List of staff assigned to support council and committees	Completed	Sorensen	
558	S13-16D4	S13-16 Deliverable 4: Organization meeting arrangements (BH Council and subcommittees)	Due 10/31/04	Sorensen	
584	S21D1	S21 Deliverable 1: Training Packages	Due 8/15/2004	Thomas	
596	S21D2	S21 Deliverable 2: Consumer group input to develop training - Section 36(1)	Due 8/15/2004	Sorensen Thomas	
598	S101D1	Section 101 Deliverable 1: System for matching SMI Consumers in Independent Housing (consumer/provider/landlord)	Due 12/31/2004	Harvey	
606	S101D2	Section 101 Deliverable 2: Recommendations to DED	Completed	Harvey	
616	S101D3	Section 101 Deliverable 3: Housing First Policy	Due 6/30/2005	Harvey	

ADULT GOAL #3: EMPOWER CONSUMERS
ACHIEVED

The Nebraska Behavioral Health Services Act (LB1083; Approved by the Governor April 14, 2004) now makes this consumer role a formal component within HHS. Within the new Division of Behavioral Health Services, there will be an Office of Consumer Affairs. Specifically, Nebraska Behavioral Health Services Act authorizes the following:

Section 5.(2) includes the following:
- The Director shall appoint … a Program Administrator for Consumer Affairs for the Division.
- The Program Administrator for Consumer Affairs shall be a consumer or former consumer of Behavioral Health services and shall have specialized knowledge, experience, or expertise relating to consumer-directed Behavioral Health services, Behavioral Health delivery

systems, and advocacy on behalf of consumers of Behavioral Health services and their families.
- The Program Administrator for Consumer Affairs shall report to the Administrator of the Division.

Section 5. (3) The Administrator of the Division shall establish and maintain an Office of Consumer Affairs within the Division. The Program Administrator for Consumer Affairs shall be responsible for the administration and management of the office.

On August 16, 2004, State Senator Jim Jensen (Chair of the Health and Human Services Committee in the Nebraska Legislature) [(402) 471-2622 or via email at jjensen@unicam.state.ne.us] released the schedule for the Mental Health Consumer Forums. Consumer information and input forums were held in each behavioral health region. The forums were sponsored by the Health and Human Services Committee and Behavioral Health Oversight Commission of the Nebraska Legislature and the Nebraska Health and Human Services System, in cooperation with the state's six Regional Behavioral Health Authorities. The purpose of the forums was to provide information to consumers about LB 1083 and the implementation of behavioral health reform in Nebraska, including the establishment of a new state Office of Consumer Affairs, and to ask for consumer input.

The dates, times and locations for the forums in each behavioral health region were as follows:

Region	Date	Time	Location
1	August 26 (Th)	9:00 – 11:00 a.m.	Gering Civic Center, Scottsbluff
2	August 26 (Th)	3:00 – 5:00 p.m.	Frontier House, North Platte
3	August 23 (Mon)	9:00 – 11:00 a.m.	Goodwill Industries, Grand Island
4	August 27 (Fri)	10:00 - 1:00 p.m.	Lifelong Learning Center, Norfolk
5	August 23 (Mon)	2:00 – 4:00 p.m.	SE Community College, Lincoln
6	August 24 (Tues)	10:00 – 12:00 noon	Omaha Public Schools TAC Building, Omaha

"Real Choice" Grant

HHSS was awarded a three-year federal grant from the Centers for Medicare and Medicaid Services (CMS) for the opportunity to review and make significant improvements to the long-term care service delivery systems. Nebraska refers to its effort as "Real Choice for Nebraskans." Under the "Real Choice" grant, HHSS has targeted its long-term care programs that serve the aging population; as well as programs that serve both children and adults with developmental disabilities, physical disabilities, behavioral health needs, and medically-complex conditions. Many of these programs currently operate in isolation of one another, even though consumers often need services across programs. It is for this reason that Nebraska proposes to undertake its systems' change grant by redirecting its philosophy of service delivery to one that is based on consumer need rather than defined by populations and funding streams.

Consumer Liaisons

The Office of Mental Health, Substance Abuse and Addiction Services has employed two consumers for over 12 years. Initially, these consumers were part time employees. In 1998, they were converted to full-time employees. The two full-time Consumer Liaisons on staff are Dan Powers and Phyllis McCaul. Overall, the consumer liaisons continue working as change agents and advocates as staff members within the Nebraska Department of Health and Human Services. Their

leadership both within the Office and in community settings changes the dynamics of a meeting, with consumer concerns being addressed more consistently. Thus, in effect, this has operated as an Office of Consumer Affairs. Now, the new legislation formalizes it and gives more formal direction to the inclusion of substance abuse and gambling consumers.

FUNDING: The Office of Mental Health, Substance Abuse and Addiction Services allocates **$305,684** annually on consumer empowerment oriented activities. This includes funding the two full-time Consumer Program Specialist (known as Consumer Liaisons) on staff as well as the Annual Consumer Conference (for about 100 mental health consumers). Annually the HHS funds a consumer conference designed to educate consumers in mental health issues and to speak up to national, state and local mental health officials to advocate on their and the systems behalf. The funding source for the consumer liaisons started as the five percent (5%) state administrative portion of the Community Mental Health Services (CMHS) Block Grant. In FY2004, the administrative portion is $105,299 (5% of $2,105,983).

The Budget for Consumer Activities in FY 2005

Revenues		
MH Block Grant 5% admin	$105,299	
MH Block Grant purchase of service	$60,000	
State Funds	$140,385	
Total		$305,684
Expenditures		
State Consumer Initiatives Contracts		
(1) National Alliance for the Mentally Ill –Nebraska - The Office contracts with the National Alliance for the Mentally Ill -Nebraska to ensure a state organizational structure is available for consumers. It will also conduct consumer sensitivity training for administrative and front line staff of mental health and substance abuse providers.	$47,750	
(2) League of Human Dignity – This contract is used to fund cash advances and reimbursements to consumers in order to help people attend meetings, workgroups and conferences.	$10,000	
(3) Mental Health Association of Nebraska – The Office contracts with the Mental Health Association to ensure a state organizational structure is available for consumers and provide consumer sensitivity training to administrative and front line staff in Nebraska nursing homes and assisted living facilities	$47,750	
(4) Partners in Recovery – for substance abuse consumers	$4,885	
(5) Each region gets $5,000 for Family Organizations – The Office partners with HHS Protection and Safety to fund family organizations to provide family mentoring services to families of SED Children. A Family Organization is funded in each region. The Office provides $5,000 per Region. +	$30,000	
State Funds		$140,385
(1) Peer Specialists - Goes to the Regions to pay for employees in Day Support who are peer specialists. *	$60,000	
(2) Two Consumer Liaisons & Annual Consumer Conference **	$105,299	

Federal MH Block Grant on Consumer Empowerment	$165,299
Total Annually on Consumer Empowerment Oriented Activities.	$305,684

* Federal MH Block Grant aid funds - not administrative set aside

** Federal MH Block Grant administrative funds portion is $105,299 (5% of $2,105,983).

+ NOTE: In FY2005 TOTAL CONTRACT WORTH $260,000
Office of Protection and Safety ($230,000)
Office of Mental Health, Substance Abuse and Addiction Services ($30,000)
The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services offered a proposal to solicit bids for a new support activity called "Families Mentoring & Supporting Other Families", a joint initiative.

WEB SITE: The Nebraska Department of Health and Human Services web site provides a summary on how to contact the Consumer Liaisons. Go to the HHS web site and click on "Behavioral Health". http://www.hhs.state.ne.us/beh/behindex.htm

- Click on: Citizen Advocacy and Planning Groups
- Click on: Mental Health Consumer Advocacy
- You will arrive at <http://www.hhs.state.ne.us/beh/mh/mhadvo.htm> On the "Mental Health Consumer Advocacy" web site there are links to national and state mental health advocacy groups.

AREAS OF WORK
This is a brief list of the areas the two Consumer Liaisons address:

- Mental Health Consumer Advocacy
- There were 110 attending the Annual Consumer Conference (September 28-30, 2004)
- Advisors on HHS Community Mental Health Policy
- Promote the development of Peer Specialists
- Advisory Panel for the "Evaluability Assessment for an Evaluation of the SAMSHA/CMHS Mental Health Block Grant Program." Dan Powers is a member of this Advisory Committee and has participated in its discussions
- Grant Reviewer Statewide Consumer Network Grant, SAMSHA. Dan Powers participated as a reviewer.
- Projects for Assistance in Transition from Homelessness (PATH) Dan Powers is the State PATH contact.
- Participate in the Consumer/Survivor Mental Health Administrators organization
- Co-Coordinate the annual Board of Mental Health Training
- Substance Abuse Consumers
- Consumer Satisfaction Program Visits
- Consumer Mailing List developed and maintained

ADULT GOAL #4: SUICIDE PREVENTION INITIATIVE
ACHIEVED

The Nebraska Statewide Suicide Prevention Initiative Committee continues to meet regularly to update and revise goals and objectives for Nebraska's suicide plan. No additional funding has been specifically budgeted or accessed for suicide planning or support of state activities.

An innovative suicide prevention program being used by the State Juvenile Detention facilities was highlighted in a poster session both at the Regional SPRC (Suicide Prevention Resource Center)/SAMSHA sponsored Region VII & VIII Conference in Colorado that took place October 28-30, 2003. The program highlighted, "The Green Line," was developed by Dr. Don Belau. As a result of this poster presentation he was invited to present a paper at the April 2004 American Association of Suicidology Conference in Miami, Florida. Two other Nebraska presenters were also featured at the Region VII and VII Colorado Conference.

The Southeast Nebraska Suicide Prevention Curricula continues to be disseminated. The core curriculum was presented by mental health consumers at the Nebraska Alliance for the Mentally Ill State Conference in 2003. It has been available for download through the University of Nebraska Public Policy Center's faith initiative site (www.nebhands.nebraska.edu) … Click on "Resources". On that web page "Resources to Assist and Answer Questions", click on "Suicide Prevention Curriculum". It was distributed to faith based and community organizations via hard copy and cd-rom through that organization. Additionally, the curriculum was distributed to a national audience at the 2004 Christian Unity Conference in Omaha, Nebraska. The curriculum was sent to Dr. David Litts of the SPRC in 2004 for use a model of public domain educational material that can be rapidly and widely disseminated and used by different groups. Additionally, the clergy module of the Southeast Nebraska Suicide Prevention Curriculum contained eulogy recommendations that were piloted for the SPRC. The evaluation data from these participants are now being analyzed in preparation for the release of the recommendations. The Law Enforcement Module has been fully integrated with the Nebraska Law Enforcement Training Academy and is now a standard part of the training that Law Enforcement recruits receive in the state of Nebraska. The health care module has been translated into video format for easy viewing by health care personnel and is a standard part of the yearly training required by at least one of the major hospitals in Nebraska (BryanLGH Medical Center). It is also regularly presented to hospitals that are part of the Heartland Health Alliance across Nebraska.

The Community Mental Health Center of Lancaster County obtained certification from the American Association of Suicidology as a Crisis Center in 2003. They are working toward participation in the Hopeline Network as a 1-800-suicide hotline resource. The other certified hotline in Nebraska is located at Boys & Girls Town in Omaha.

The state committee participated in the development of Nebraska's injury prevention planning in the area of suicide prevention in 2004. The committee will have a regular presence in 2004 with the health department advisory group that includes planning for intentional self harm and youth prevention efforts.

What's next?
The goals for the State Suicide Prevention Committee include supporting ongoing state wide efforts to de-stigmatize mental health and seeking help through support of "Project Relate" – a public relations campaign sponsored by a number of organizations including the Kim Foundation and Omaha Federation of Advertising, NAMI, and a number of health care providers. (www.projectrelate.org) No direct state funding is anticipated for the next few years in this area, so

the committee will focus on supporting private efforts and finding innovative ways to create awareness and participate in research while furthering best practices.

Nebraska is in the midst of a behavioral health reform project that will create exciting new opportunities for further dissemination of suicide prevention information to communities in the coming months. It is anticipated that there will be an increased role for Nebraska's prevention networks in this effort.

On October 1, 2004, the Suicide Prevention Resource Center (SPRC) launched a new web service as part of its ongoing commitment to help states build capacity to implement and evaluate suicide prevention programs.

The State Suicide Prevention Web Pages serve as a central collection of information about suicide prevention efforts for each state and provide a forum for sharing communication and resources within and across states. Each page includes a brief history of state suicide prevention efforts, highlights of current activities, a link to the state plan, scope of the state plan, state data, legislation, resources, funding sources and more.

The launch of the pages is a phased one. Currently, information for 12 states is available, and over the next several weeks, SPRC will launch the remaining pages in stages.

> "States have the ability to submit updated information for their own pages, and we encourage them to build on the initial efforts made by SPRC," said Ramya Sundararaman, SPRC Prevention Support Coordinator. States can submit up-to-date information by filling out a web-based form that can be found on each of the state pages.
>
> In the development of the State Suicide Prevention Web Pages, SPRC drew heavily on Davis C. Hayden's State Plans for Suicide Prevention web site. "We are grateful for Dr. Hayden's pioneering contribution in collecting information on state plans and are honored to continue his efforts through SPRC's State Suicide Prevention Web Pages," said Dr. Sundararaman.

To view the State Suicide Prevention Web Pages, please visit http://www.sprc.org/statepages/.

SECTION THREE:
ADULTS– ACCOMPLISHMENTS
PERFORMANCE INDICATORS

- State-Selected Performance Indicators and the CMHS Core Performance Indicators

FY 2004 Nebraska MENTAL HEALTH PLAN
Criterion 1: Comprehensive Community- based Mental Health Service Systems

GOAL: Maintain capacity of Community Support Services

OBJECTIVE: In light of current state budget, by June 30, 2003, the number of persons served with Serious Mental Illness receiving Mental Health Community Support Services will remain at current capacity (as of July 2003, there are about 2,450 slots of Community Support services).

POPULATION: SMI Adults

Performance Indicator (1)	**FY2002** Actual	**FY2003** Actual	**FY2004** Objective	**FY2004** Actual	**% Attained**
Value:	2,607	2,644	2,600	2,832	+7.1%

Number of persons SMI who are receiving Mental Health Community Support (including case management) services

Value = all persons reported SMI receiving Mental Health Community Support

Community Support - Mental Health
Medicaid Rehabilitation Option (MRO ELIGIBLE and NON-MRO ELIGIBLE)

	FY03 # Persons Served	% of Total	FY04 # Persons Served	% of Total	Population (2000)	
					#	% of state population
Region 1 totals	166	6.3%	141	4.98%	90,410	5.3%
Region 2 totals	239	9.0%	242	8.55%	102,311	6.0%
Region 3 totals	289	10.9%	363	12.82%	223,143	13.0%
Region 4 total	277	10.5%	293	10.35%	216,338	12.6%
Region 5 totals	1185	44.8%	1345	47.49%	413,557	24.2%
Region 6 Totals	488	18.5%	448	15.82%	665,454	38.9%
Totals Regions 1-6	2644	100.0%	2832	100.00%	1,711,213	100.0%
Source: as reported by the Six Regional Behavioral Health Authorities, September 2004						

Criterion 2: **Mental Health System Data Epidemiology**
FY 2004 Nebraska MENTAL HEALTH PLAN
PERFORMANCE INDICATORS
GOAL: To maintain the number of people receiving Mental Health Services.
OBJECTIVE: To maintain the number of persons age 18 or older (unduplicated count) in FY2004 (no cut in program capacity).
POPULATION: Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS)

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value: M H Services only	15,962	17,328	17,000	16,620	Not Applicable*

*The data for FY2004 persons served Total age 18 + is 16,620. This is the first year of reporting the Federal Uniform Reporting System using the new capacity for data analysis in order to report an unduplicated count of persons served between the three Regional Centers (State Psychiatric Hospitals) using AIMS data and community mental health using Magellan Data. Summary from FY2004 Table 2A "Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity"

Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

	Table 2A
	Total
0-3 Years	179
4-12 years	595
13-17 years	1,002
Total age 0-17	1,776
18-20 years	1,062
21-64 years	15,014
65-74 years	342
75+ years	195
Not Available	7
Total age 18+	16,620
Total	18,396

NOTE: The total persons served (18,396) for 2004 is less than what was reported for Table 2A in the FY2003 report (19,865). This does not show a cut in the number of persons served. Starting FY2004, it does reflect an improved capacity to report unduplicated persons served between the community mental health (Magellan data) and the Regional Centers (AIMS Data for the State Psychiatric Hospitals. This is a new system for completing the data analysis for the Federal Uniform Reporting System that has been implemented in Nebraska. The FY2002 and FY2003 Uniform Reporting System data are subject to revision based on the new approach in data analysis.

This improved capacity was discussed in GAP #4: INFORMATION SYSTEM IS INADEQUATE.

Criterion 4: Targeted Services to Rural and Homeless Populations

GOAL: With the Rural Mental Health Program, provide services to the rural residents of Nebraska impacted by the prolonged decline of the farm/rural economy in Nebraska.

OBJECTIVE: In FY2004, provide 2,500 counseling sessions to 800 people (individuals or families) under the crisis counseling vouchers program.

POPULATION: Residents of Nebraska's rural and frontier areas including farmers, ranchers, spouses, children, and others who are directly affected by the continued economic crisis.

Value: average number of sessions per individual/family
Numerator: unduplicated count / people served (individual or family)
Denominator: total number of counseling sessions

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN	
Value:	4.2	2.4	3.1	3.14	#	**%**
Numerator	625	845	800	901	101	+12.6%
Denominator	2625	2025	2500	2834	809	+32.4%

% Attain is based on the 2,500 counseling sessions (Denominator) to 800 people (Numerator). In FY2004, the Rural Mental Health Program served 101 (12.6%) more people and provided 809 (32.4%) more sessions than projected.

Discussion:

- In FY 2002, the Rural Mental Health Hotline and Voucher Program budget was increased to $100,000. (Hotline; $20,000; Voucher program $80,000). In FY 2003 and FY 2004, the budget remained at the same level of funding as FY 2002. In FY 2004, the $100,000 was moved to the Voucher Program.

Data source: from NE Office of Mental Health, Substance Abuse and Addiction Services

Criterion 5: Management Systems

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services
OBJECTIVE: By June 30, 2004, the per capita state expenditures for community mental health services will be maintained over $15.00
POPULATION: Total population

Per Capita State Expenditures for Community Mental Health Services

Numerator = "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)
Numerator Data source: Office of Mental Health, Substance Abuse and Addiction Services

Denominator = Total State population
Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm>

Performance	FY 2002	FY 2003	FY 2004	FY2004	% ATTAIN

Indicator:	Actual	Actual	Objective	Actual	
Value:	$14.03	$16.97	over $15.00	$18.24	$3.24 (21.6%).
Numerator	$24,015,746	$29,036,852		$31,207,611	
Denominator	1,711,263	1,711,263		1,711,263	

The change from FY2003 to FY2004 was +$1.27 (7.5%). The goal was to maintain the per capita expenditure at over $15.00. On that basis, the goal was attained by over $3.24 (21.6%).

Federal Requirements
PART B. Administrative Requirements, Fiscal Planning Assumptions, and Special Guidance
II. Maintenance of Effort Report (MOE)

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Mental Health Services		
Actual 2002	Actual 2003	Actual/Estimated 2004
$24,015,746	**$29,036,852**	**$31,207,611**

SECTION FOUR:
CHILDREN – ACCOMPLISHMENTS
FY2004 GOALS FOR CHILDREN OR ADOLESCENTS

GOAL #1: STRATEGIC PLANNING
ACHIEVED

For younger children, Nebraska Health and Human Services has submitted an application to the U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**; (3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families. Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;
4. Identify and rank priority needs and issues in each of the five essential components;
5. Develop strategies and associated action plans for each of the priority needs and issues;
6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

A participatory planning process, using a comprehensive planning model, has been selected as the methodology. This model meets the criteria of bringing together various and diverse organizations and individuals to create consensus and make prudent decisions about the future of early childhood comprehensive systems. This model is based on six basic steps: (1) issue identification/orientation, (2) exploration/investigation, (4) defining the planning of task or goal setting, (4) policy formation, (5) programming, and (6) evaluation. A consultant will guide participants in the process, and provide technical assistance to build stakeholder capacity to carry out the plan and continue planning efforts in the future. A full-time project coordinator will work with an Advisory Committee, a Project Leadership Team, and eight Work Groups.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) will serve as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project measures progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The proposed 2-year planning project will focus on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. The Department of Health and Human Services has recently been notified that this project has been funded.
Source: ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services, 2003.

Nebraska has been granted a FY04 state infrastructure grant to support systems of care at the state level. Although some Nebraska communities have developed comprehensive, integrated systems of care that provide exceptional services for children and families, these efforts are islands of excellence in a troubled sea. The State has significant challenges in appropriately addressing the behavioral health needs of its children and their families. Vast areas of the state are frontier and rural and have severe shortages of mental health and substance abuse professionals. Of Nebraska's 93 counties, 86 are designated psychiatric shortage areas. Even when services are available, families have difficulty affording behavioral healthcare; Nebraska has seven of the 12 poorest counties in the nation. According to an Omaha World Herald expose' on children's mental health, one in four families of children with serious mental health problems were encouraged to relinquished custody of their child just to access behavioral healthcare that they could not afford; Nebraska has the highest number of children per capita in the country who are wards of the state. Nebraska has a growing population of ethnic/racial minorities; these populations present unique behavioral health needs that the current system is ill prepared to meet. Other challenges include fragmentation across systems, lack of evidence-based services, and funding structures that are not supportive of individualized, family-centered care.

Specifically the State Infrastructure Grant application will help expand wraparound across systems, develop service models for challenging populations (children ages birth through 5, transition-aged youth, and youth with co-occurring substance abuse and mental health disorders), establish culturally and linguistically appropriate practices, and create a forum for state agencies to work with stakeholders to develop an integrated, family-centered behavioral healthcare system for children and families. A wide array of stakeholders are committed to this project including the state agencies responsible for mental health, substance abuse, Medicaid, child welfare, juvenile justice, education, vocational rehabilitation, public health, and developmental disabilities. Local systems of care have also committed to the success of this project including the two SAMHSA system of care grantees (Nebraska Families Central and Families First and Foremost), the two Safe Schools, Healthy Students grantees in Omaha and Beatrice, and the Governor's early childhood mental health system of care initiative in central Nebraska. Other stakeholders committed to the project include two family organizations (NAMI-Nebraska and the Nebraska Federation of Families for Children's Mental Health), three state commissions (Nebraska Commission on Indian Affairs, Mexican American Commission, and the Crime Commission), other system of care communities such as Panhandle Partnership for Health and Human Services, provider organizations, faith organizations, University of Nebraska (Public Policy Center, Center for At-Risk Children's Services, Monroe-Meyer Institute) private foundations, and the Nebraska Legislature's Health and Human Services Committee. The need for infrastructure development identified in this application is wholly consistent with the priorities of Nebraska. Through the leadership of the Governor and the Legislature's Health and Human Services Committee, Nebraska enacted major legislation this spring designed to ensure access to behavioral health services, create an appropriate array of community-based services and a continuum of care, coordinate behavioral healthcare with primary healthcare services, develop services that are research based and consumer focused, ensure consumer involvement as a priority in all aspects of service planning and delivery, and develop funding that is fully integrated and supports a plan of treatment.

Utilizing resources outside the mental health system increases efforts to provide mental health services for children. Programs for target children continue to be developed using funds from outside the mental health system. One such funding initiative is the Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) Federal Grant. VOI/TIS funding is offered by the federal government to assist states in addressing issues of violent offenders and overcrowding in their juvenile correctional facilities. Nebraska was awarded VOIT/TIS funding in the amount of approximately $4 million to increase bed capacity for violent juvenile offenders and to address issues of overcrowding in the Youth Rehabilitation and Treatment Center (YRTC) in Kearney. Nebraska is required to provide a 10% match. Nebraska identified two specific services to assist the YRTC in Kearney to address their overcrowding. HHS/OJS and the facility are working to implement and operationalize these two programs at the present time. One program being established is a sexual offender program, and the other is a culturally sensitive transitional program for African-American youth. All youth referred to either of these programs will remain committed to the YRTC-K, but be served at a site other than the main campus. The alternative site programs will be self-contained and offer specialized services to meet the behavioral, emotional, and physical needs of these particular youth.

The Sexual Offender Program will be located in Lincoln and will be able to serve approximately 7-9 male juveniles. Youth in this program will have significant functional impairments due to emotional disorders, as well as cognitive and/or sexual behavioral impairments. They will have

persistent patterns of disruptive behavior and disturbance in age-appropriate adaptive functioning, and be at very high risk for causing harm to self or others. Youth will receive specialized services to address their sexual offender issues and other issues impacting their daily functioning. This program was targeted for implementation last year, but has not yet been implemented. Plans continue for implementation.

The Transitional Living Program will be located in Omaha and will be able to provide culturally sensitive alternative programming for 8-10 African-American juvenile males instead of traditional programming at YRTC-Kearney. This program will concentrate on teaching these youth viable independent living skills for success in the future and to divert them from any future delinquent behaviors. Youth in this program will also have significant functional impairments due to emotional disorders and possibly have cognitive impairments. They will have persistent patterns of disruptive behaviors, disturbance in age-appropriate adaptive functioning, and be at risk for causing harm to self or others. In addition, they will receive services to improve upon their lack of vocational, interpersonal, and social skills generally considered necessary to live in the mainstream of society and be drug-free, free of criminal behavior, and legitimately successful. Offering such a culturally sensitive program will also enable the department to begin to address the issue of disproportionate minority confinement (DMC). This program was also targeted for implementation last year, but has not yet been implemented. Plans continue for implementation.

Nebraska Health and Human Services, with assistance from NASMHPD, sought technical assistance from the Bazelon Center for Mental Health Law in resolving the issue of custody relinquishment of children in order for them to access mental health services. Nebraska Federation for Families and the integrated finance committee from the two federal grant sites participated in conversation and presentations with Mary Giliberti, JD, from the Bazelon Center that explored alternative access to services for families who historically may have surrendered custody of their children to the state in order to receive Mental Health services. The proposal to explore funding for wraparound services funded by the Children's Medicaid Waiver was initiated, but again fell by the wayside in response to proposed Medicaid cuts. However, renewed interest to resurrect these efforts has been shown by Nebraska provider organizations (NABHO) and technical assistance will again be sought to accomplish implementation.

Three new wraparound programs –Integrated Care Coordination Units - for state wards have been funded by the Office of Protection and Safety, and provide new opportunities for youth in the Protection and Safety system. We would like to see additional funds for the Professional Partner Program, which provides wraparound services for non-wards. In Region 3, cost savings from the ICCUs has been appropriated to prevent at risk children from becoming wards (i.e. custody relinquishment) by providing wraparound services. We hope this trend continues.

GOAL 2: FAMILY SUPPORT
ACHIEVED
Projects involving the support of families include: The Office of Protection and Safety and the Office of Mental Health, Substance Abuse and Addiction Services fund a new support activity called "Families Mentoring & Supporting Other Families", a joint initiative to request proposals from qualified sources to provide:

A. Strength-based, family centered, and partnership oriented supports to:
   1) parents across the State of Nebraska whose children have been made state wards, or are in a voluntary case, or
   2) parent who are involved with the department as a result of a report of abuse/neglect, or
   3) parents whose children are diagnosed with a serious emotional disturbance and substance dependence disorders.
B. The intent is to ensure that parents have a voice, ownership and access to the systems of care for their child (i.e. case plans, individual educational plans, treatment plans and any other care plan).

The outcomes for parents served are:
1. To have support of other families that are coping with similar challenges.
2. To reduce parental feelings of emotional and social isolation that sometimes occur in parenting a child with emotional and behavioral challenges.
3. To have referral sources to access the appropriate services for their child and other family members.
4. To be equal partners in the system of care.
5. To learn how to enhance communication and networking with the professionals involved in the case.

The program objectives are to support one parent organization within each of the service areas/regions, for all individual parent organizations awarded contracts to come together and form a consortium so there is some commonality and consistency between the 6 service areas/regions organizations and an opportunity for statewide issues to be addressed. HHS has a collaborative relationship with the consortium. The consortium members may be required to meet with HHS via telephone conference calls on a quarterly basis and in-person one-two times per year. They deliver parent to parent supports that are efficient, effective and responsive as well as tailored to the unique and individualized needs of the child and family and measure and demonstrate the parent outcomes outlined above.

All supports are community-based and provided at the local community level. Organizations must ensure supports have the capacity to address the unique culture of each family and child. Organizational supports need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Organizations integrate diversity into their practices and products so that interactions with individual children and their families can be mindful of, and honor, the family's home culture.

One organization has been selected from each of six service areas of Health and Human Services and the corresponding mental health and substance abuse regions to develop a program that will provide supports to targeted families (1) whose children have been made state wards, (2) are involved with the department as a result of a report of abuse/neglect, or (3) whose children are diagnosed with a severe emotional disturbance and substance dependence disorders.

In addition, NAMI –Nebraska has purchased the “Visions for Tomorrow” curriculum to provide education and support to families in southeast Nebraska. Visions for Tomorrow education workshops are designed for caregivers of children and adolescents who have been diagnosed with a brain disorder as well as those who exhibit behavior that strongly suggests such a diagnosis.

i. There is no charge for the course for the caregivers.
ii. Visions' teachers are caregivers themselves.
iii. The course has been designed and written by experienced caregivers, family members and professionals.
iv. The course balances basic psycho-education and skill training with self-care, emotional support and empowerment.

Purpose is to provide basic education and knowledge of various brain disorders, to provide general information for networking with support groups and dealing with the different systems of care and to provide basic information and methods needed to advocate for persons with brain disorders. The project is slated to begin in September of 2004.

Although the number family support projects continue to increase, a large number of caregivers of children with disabilities, including SED, continue to live in isolation without support. A large number of grandparents are now raising their grandchildren, and a proportionate number of those children have disabilities. Providers report that they are observing a trend in the number of grandparents who are raising their grandchildren. The grandparents have reported that programs which recognize the unique needs of older adults raising children with disabilities seem to be virtually nonexistent in Nebraska.

GOAL #3: INTEGRATION OF SERVICE SYSTEMS
ACHIEVED

For younger children, Nebraska Health and Human Services has received assistance from U.S. Maternal and Child Health Bureau for the **State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program**. Nebraska state agencies, in partnership with professional organizations, community-based providers, families, and advocates, have made significant progress in addressing various aspects of early childhood systems of care. Several initiatives have resulted in planning documents and pilot projects. A major challenge that remains is to achieve an integrated, comprehensive plan that addresses the five key components of: (1) access to health care and a medical home; (2) **mental health and socio-emotional development**; (3) early care and education/child care; (4) parent education; and (5) family support. In addition, a number of other challenges are being faced in Nebraska that impact upon the health and well-being of Nebraska's young children and their families and the system that supports early childhood programs and services. Among these are an increasingly diverse populations and large expanses of rural and sparsely populated areas. In addition, gaps exist in data availability and utilization, including an absence of agreed-upon early childhood indicators.

The goal for this proposed project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The 2-year planning project focuses on processes and products that will be essential for laying the foundation for effective implementation of a strategic plan and the ultimate realization of improved outcomes for young children and their families. Objectives include:

1. Establish a planning structure and process that engages the full spectrum of early childhood stakeholders, with an emphasis on family involvement;
2. Develop vision and mission statements and identify key outcomes for young children and the early childhood system in each of the five essential components;
3. Develop a set of indicators linked to outcomes;

4. Identify and rank priority needs and issues in each of the five essential components;
5. Develop strategies and associated action plans for each of the priority needs and issues;
6. Obtain commitments to accept and implement the strategic plan from key policy makers; and
7. Develop a comprehensive plan for sustaining the effort.

A participatory planning process, using a comprehensive planning model, has been selected as the methodology. This model meets the criteria of bringing together various and diverse organizations and individuals to create consensus and make prudent decisions about the future of early childhood comprehensive systems. This model is based on six basic steps: (1) issue identification/orientation, (2) exploration/investigation, (4) defining the planning of task or goal setting, (4) policy formation, (5) programming, and (6) evaluation. A consultant will guide participants in the process, and provide technical assistance to build stakeholder capacity to carry out the plan and continue planning efforts in the future. A full-time project coordinator will work with an Advisory Committee, a Project Leadership Team, and eight Work Groups.

The Governor-appointed Early Childhood Interagency Coordinating Council (ECICC) serves as the Project Advisory Committee. The ECICC has done extensive work in examining early childhood care and education issues, and its membership represents a wide range of interests, including child care providers, state agencies, parents, business, health care providers, and others. In addition, a 20 – 30 member Project Leadership Team will engage representatives of state agencies, Tribal government, provider and family associations, advocacy groups, the business community, military installations, and other important stakeholders. Eight work groups will further facilitate involvement and coordination with state-level and community-based efforts. Planning activities will actively build on earlier and existing initiatives.

The project measures progress in achieving seven planning phase outcomes and five short-term implementation outcomes. The planning phase outcomes are: (1) linkages formed among system and community/client stakeholders; (2) planning structure and staff established and functional; (3) workgroups formed, oriented to process, and prepared to carry out assignments; (4) community/stakeholder vision and mission developed; (5) strategies consistent with vision and mission; (6) policy changes identified to drive implementation phase; and (7) public support for change enhanced. The five short-term implementation outcomes are: (1) a model for shared decision making disseminated system wide; (2) improved capacity among stakeholders in the area of policy development; (3) information and administration infrastructure in place to increase exchanges; (4) system improvement resulting from training and coaching of stakeholders; and (5) ongoing stakeholder participation and data to improve early childhood systems planning.

The goal of this project is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. The focuses on processes and products that will be essential for laying the foundation for effective implementation of a comprehensive strategic plan and the ultimate realization of improved outcomes for young children and their families. **Source:** ABSTRACT, Nebraska's Comprehensive Early Childhood Strategic Planning Project, Nebraska Department of Health and Human Services.

The ICCU is a public care coordination collaborative that includes Department of Health and Human Services Division of Protection and Safety and Region III Behavioral Health Services Care Coordinators who will ensure that care is individualized and adhere to the following wraparound principles: A no reject/eject philosophy, comprehensive assessment to determine the child and

family's needs, child and family team consisting of both professionals and non-professionals who know the child and family, a Care Coordinator, with a caseload of 1:10, to facilitate the child and family team, development of an Individualized Child/Family Support Plan based on the strengths of the child and family; strategies that are individualized to the child and family's needs and based on the family's cultural background. Through flexible funding, purchase of services and supports identified in the plan are made. Use of community teams to broker informal resources to support families and monitoring of outcomes and modification of strategies to produce better results are also used.

Other important system components include family operated support and advocacy organization for families of children with serious emotional and behavioral issues, the **Care Management Team** which provides utilization management/review, a strong cross agency **Program Evaluation** component which collects demographics, service utilization, cost, and outcome data, and the **ICCU Director's** with membership consisting of key representatives of the three system partners .
The children and adolescents served share the following characteristics:

- High functional impairments in multiple areas (e.g., school, home, community, self harm, substance abuse)
- Persistent problems over long term
- Multi-agency involvement
- High service costs (although they constitute less than 25% of the state ward population in Central Nebraska, they use almost 70% of the resources).
- Poor outcomes in traditional services

SECTION FOUR:
CHILDREN – ACCOMPLISHMENTS
PERFORMANCE INDICATORS

CRITERION 1: COMPREHENSIVE COMMUNITY- BASED MENTAL HEALTH SERVICE SYSTEMS

GOAL #1:	Maintain capacity of Professional Partner (wraparound) program for children with serious emotional disturbance.
POPULATION:	Children and adolescents with serious emotional and behavioral disorders
OBJECTIVE:	The number of children participating in Professional Partner wraparound program will be maintained.
CRITERION:	#1 Comprehensive, community-based mental health system
BRIEF NAME:	Children enrolled in Professional Partner
INDICATOR:	The number of children participating in Professional Partner services
MEASURE:	Count of number of children participating in Professional Partners as of June 30 of each year.
SOURCE OF INFORMATION:	FY04 Actuals

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value: Children in Professional Partner	365	644	644	849	31.8%

In FY2004, the number of children participating in Professional Partner services increased by 205 for a total of 849 (31.8%).

Criterion 2: Mental Health System Data Epidemiology

GOAL #2:	To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System.
POPULATION:	Children and adolescents receiving Mental Health Services
OBJECTIVE:	The number of children receiving services will be maintained
CRITERION:	#1 Comprehensive, community-based mental health system
BRIEF NAME:	Persons age 0-17 receiving services
INDICATOR:	The number of children receiving services
MEASURE:	Count of number of children receiving services
SOURCE OF INFORMATION:	FY04 Actuals as submitted by Regions*

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value: Children receiving services	2257	2765	2765	4242	

* Note change of source of information; Magellan data (previous source) unavailable at this time

Criterion 3: Children's Services

GOAL #3:	To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs
POPULATION:	Children with serious emotional disorders who are wards of the state
OBJECTIVE:	The number of children who are in the custody of the state and who receive integrated care coordination will increase by 5%.
CRITERION:	Children's Services
BRIEF NAME:	Integrated care coordination for state wards with SED
INDICATOR:	The number of children receiving integrated care coordination
MEASURE:	Count of children receiving integrated care coordination
SOURCE OF INFORMATION:	ICCU Director
SIGNIFICANCE:	Emerging body of research indicates intensive case management using the wraparound approach can be effective in ensuring appropriate services and reducing expenses of using high cost services

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value: Number of wards in ICC	222	457	500	1000	100%

Criterion 4: Targeted Services to Rural and Homeless Populations

GOAL #4:	To provide services to all children in non-Metropolitan areas.
POPULATION:	Children receiving services through the "Voucher Program" in non-Metro areas
OBJECTIVE:	The number of children in non Metropolitan areas receiving services will be maintained.
CRITERION:	Targeted Services to Rural and Homeless Populations
BRIEF NAME:	Non Metropolitan children
INDICATOR:	Number of children receiving "Voucher" services
MEASURE:	Count of Non-Metropolitan children receiving services
SOURCE OF INFORMATION:	Database for Rural Crisis Voucher Program

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value: Number of children in non-Metropolitan areas receiving Voucher services:	278	209	209	339	162%

In FY2004, the number of children receiving "Voucher" services increased by 130 for a total of 339 (62.2%).

Criterion 5: Management Systems

GOAL: At least maintain the Per Capita State Expenditures for Community Mental Health Services
OBJECTIVE: By June 30, 2004, there will be at least the same level of spending in per capita state expenditures for children's community mental health services at $8.82.
POPULATION: Total children's population ages 0-17 years.
Per Capita State Expenditures for Community Mental Health Services
Numerator = Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)
Data source: Office of Mental Health, Substance Abuse and Addiction Services
Denominator = per Capita ...Total children's population ages 0-17 years (450, 242)
Data Source: Nebraska Databook, Last Updated on 5/21/01 based on data from U. S. Bureau of the Census Web site (www.census.gov) 2001 <http://info.neded.org/stathand/bsect8.htm >.

Performance Indicator:	FY 2002 Actual	FY 2003 Actual	FY 2004 Objective	FY2004 Actual	% ATTAIN
Value:	$8.43	$8.60	$8.49	$9.62	$1.13 (13.3%)
Numerator	$3,793,391	$3,872,010	$3,820,804	$4,332,646	
Denominator	450,242	450,242	450,242	450,242	

The State Expenditures for children's Community Mental Health Services increased by $511,842. That means the Per Capita State Expenditures for children's Community Mental Health Services increased by $1.13 (13.3%).

Set-Aside for Children's Mental Health Services

DATA REPORTED BY: State Fiscal Year (July 1 to June 30)

State Expenditures for Children's Services			
Calculated 1994	Actual 2002	Actual 2003	Actual/Estimated 2004 *
$620,801	**$3,793,391**	**$3,872,010**	**$4,332,646**

STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES

- **COMMENTS FROM THE COMMITTEE**
- **LETTER FROM THE CHAIR**

The State Advisory Committee on Mental Health Services met on November 10, 2004. Members present were Wayne Adamson, Jimmy Burke, Richard Ellis, Wesley Legan, Darlene Richards, Dwain Fowler, Clint Hawkins, Nancy Kratky, Susan Krome, Mary Wells, James Deaver, Beth Baxter, Allen Bartels, Maria Prendes-Lintel, Beth Wierda, Cec Brady, and Lara Huskey. HHS staff present included Dan Powers, Jim Harvey, Sue Adams, and, Alexandra Castillo. Members of the public were also present.

Allen Bartels was elected chair.

The review and comment on the FY2004 Federal Community Mental Health Services Block Grant Implementation Report took place. Comments on the draft Report are below.

COMMENTS FROM THE COMMITTEE

- page 8 - On the number of Nebraska youth census data and SED Estimate. He noted Census data shows 227,347 age 9 to 17 … Federal SED estimate is 22,735. Is it a Coincidence that the SED number is 10% to the census number?
- Page 10 – school to work plan – needs to be explaned to transitions to the community.
- Page 41 – education system is not listed.
- Page 42 – ECICC – who are these people?
- Page 44 – need to be involved in the alternative school.
- Page 56 – could get number from the FY2005-2006 from the Omaha School District.
- one of challenges is definitions … Mental Health system uses SED … the education system has different definition.
- page 18 on LB95 Medications … does a person have to be committed to a state facility in order to use that program? As we go to community based services, the consumer will need these medications. Access to those funds is cumbersome as the program is currently handled. Group discussion was triggered. Outpatient commitment needs to be included on the LB95 medications program. Access to medication is one of the huge problems.
- Page 19 – Cultural Competent Services – this gap needs to be better addressed. There needs to be a specific set of goals, objectives and activities designed to address these issues. Many issues involved here including not having enough qualified interpreters. A bad interpreter can make things worse for the consumer. Competency includes medications because different groups react differently to different medications. The Omaha Public Schools have students speaking 38 different languages from 50 different countries.
- Elderly are under served. For example, there is a lack of transportation for elderly. As a result, seniors get isolated. Depression can be a serious issue for them.
- on children section, one suggestion is to talk about family centered approach. This needs to include actually listening to children. Is there anyway we can have some of youth talk about what they say about mental health improvements? Lets listen to youth across state. Youth need to involved in what they think is important for services. How do youth actually understand the services they receive? Why not have a youth on a committee like this, or a committee of youth to make proposals to see what they really are think. Adults make assumptions about the way youth feel, but do not listen to what youth actually say.

PUBLIC COMMENT

- CMS has indicated that Medicaid eligibility can be placed on hold while a consumer is in an institution. That can help the consumer to immediately get medications upon release.
- sometimes LB95 medications do not cover the newer medications
- Did the committee receive copy of the final FY2005 application as it was delivered to the Center for Mental Health Services?
- Did the committee get a copy of the draft Implementation report in advance of this meeting?
- Can the specific responses to the 28 item MHSIP Consumer survey be released?
- Can there be two times on the committee agenda for public comment? One time at the beginning regarding the agenda, and one time at the end of the meeting?

Nebraska State Advisory Committee on Mental Health Services

November 14, 2004

LouEllen Rice
Grants Management Office, Room 7-1079
Division of Grants Management
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice

This letter is intended to verify that on November 10, 2004, the Nebraska Mental Health and Evaluation Council met in Lincoln Nebraska to review the Nebraska State Plan Implementation Report for FY2004. The plan was presented to the committee, and its contents were discussed. Some of the committee's comments are as follows:

- There needs to be explanation of the school to work plan for transition to the community.
- While it is hoped that there will be progress made regarding the lack of "step down" services, there is remaining concern about the continuing absences of these services.
- There is concern regarding the issue of Medication Access. There needs to be clarification regarding a person's needs to be committed to a state facility in order to have access to LB95 medications. If this is still the case, then this must be addressed. Outpatient commitments also need access to LB95 funds and the process needs to be much less cumbersome. The committee agreed that medication access is a problem and that if this problem isn't solved, real reform will be difficult, not just in Nebraska, but across the nation.
- Many on the committee felt that Culturally Competent Services need to be better addressed. It was suggested that there needs to be specific goals, objectives and activities designed to address this issue.
- There was discussion regarding the elderly being underserved.
- Regarding the children's section, there was discussion regarding the need for a family centered approach. It was requested that we consider having some youth on the committee, or at least having a chance to talk to some youth who are getting services. It was suggested that adults make assumptions about the way youth feel, but that they do not listen to what youth actually say.

The committee also heard comments from the public regarding the issues of:

- Medication access
- Committee functions and procedures

After this discussion and comment, the consensus of the Council was to support submission of the report.

Sincerely,

Allen Bartels RNC, MS
Chair, Nebraska State Advisory Committee on Mental Health Services

PART E – UNIFORM DATA ON PUBLIC MENTAL HEALTH SYSTEM
State Level Data Reporting Capacity Checklist – FY2004 State Reports
Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Age	YES	YES		YES		
Gender	YES	YES		YES		
Race/Ethnicity Categories						
New Federal Race and Hispanic Origin Categories are Used in Community Settings	YES		YES	YES		
New Federal Race and Hispanic Origin Categories are Used in State Hospitals	NO				UNKNOWN	
Living Situation Categories						
Homeless Status of Persons Served in the Community	YES	YES		YES		
Persons Served - State psychiatric hospitals	YES		YES	YES		
Persons Served - Other psychiatric hospitals ++	NO				UNKNOWN	
Employment Status Categories						
Full time or part time Competitive Employment	YES	YES		YES		
Unemployed	YES	YES		YES		
- Not in Labor Force	YES	YES		YES		

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Patient Funding Support Categories						
Persons Served Through Medicaid Only	NO				UNKNOWN	
Persons Served Through Other Funding Sources Only	NO				UNKNOWN	
Persons Served by Both Medicaid and Non-Medicaid Sources	NO				UNKNOWN	
Client Turnover Status Categories						
State Hospitals - Admissions	YES		YES	YES		
State Hospital B Discharges	YES		YES	YES		
State Hospital B Average length of service (ALOS) (discharges)	YES		YES	YES		
State Hospital B ALOS (residents at end of year)	YES		YES	YES		
Other Inpatient Settings – Admissions ++	NO				UNKNOWN	
Other Inpatient Settings – Discharges	NO				UNKNOWN	
Other Inpatient Settings - ALOS (discharges)	NO				UNKNOWN	
Other Inpatient Settings - ALOS (residents at end of year)	NO				UNKNOWN	

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES, Using Federal CMHS definitions/ categories? (Yes/No)	IF NO, Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Block Grant Non-Direct Service Expenditure Categories						
Technical Assistance	YES	YES		YES		
Planning Council	YES	YES		YES		
Administration	YES	YES		YES		
Data collection/ reporting	YES	YES		YES		
Other Activities	YES	YES		YES		
Dual Diagnosis Status Categories						
Adults Served Who Had a Diagnosis of Substance Abuse and MH	YES	YES		YES		
Adults with SMI Served Who Had a Diagnosis of SA and MH	YES	YES		YES		
Children Served Who Had a Diagnosis of SA and MH	YES	YES		YES		
Children with SED Served Who Had a Diagnosis of SA and MH	YES	YES		YES		

++ Regarding Other psychiatric hospitals: Nebraska captures these data as part of the Magellan Behavioral Health Data System under the community programs. However, there is no data capture for "Other Psychiatric Hospitals" services not funded by State Mental Health Authority.

State Level Data Reporting Capacity Checklist - Developmental Tables

Please complete the following form indicating the capacity of the State Mental Health Authority to report the following data elements.

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Operational Definition to Identify Adults with SMI	YES		YES	YES		
Operational Definition to Identify Children with SED	YES		YES	YES		
Living arrangement - Living in Private Residence	YES		YES	YES		
Living arrangement- Living in Foster Care	YES		YES	YES		
Living arrangement - other 24-hr residential	YES		YES	YES		
Evidence-Based Practices						
Supported Housing Services	NO				UNKNOWN	
Supported Employment Services	NO				UNKNOWN	
Assertive Community Treatment (ACT) programs	YES		YES	YES		
New Generation Medications in State Hospitals	NO				UNKNOWN	
New Generation Medications in Community Settings	NO				UNKNOWN	
Integrated Treatment for	NO				UNKNOWN	

Data Element	Can the State provide this data element currently? (Yes/No)	IF YES,			IF NO,	
		Using Federal CMHS provisional definitions/ categories? (Yes/No)	Using State definitions/ categories, if different? (Yes/No)	Does the State collect these data at the individual client level? (Yes/No)	Does the State intend to develop a reporting capacity for this data element? (Yes/No)	If Yes, by when will this capacity be in place? (Calendar Year)
Persons with Mental Illness and Substance Abuse						
Therapeutic foster care	NO				UNKNOWN	
Family PsychoEducation	NO				UNKNOWN	
Illness Management and Recovery Skills	NO				UNKNOWN	
Outcome Measures						
School attendance - Children=s	NO				UNKNOWN	
School Performance – Children	NO				UNKNOWN	
Criminal justice involvement – Adults	NO				UNKNOWN	
Criminal justice involvement – Children	NO				UNKNOWN	

PART E – UNIFORM DATA ON PUBLIC MENTAL HEALTH SYSTEM

UNIFORM REPORTING TABLES